CHATHAM KENT CHILDREN'S SERVICES
495 Grand Avenue West
Chatham, Ontario N7L 1C5
Phone: (519) 352-0440 X 2
Fax: (519) 358-4118
mhdevintake@ckcs.on.ca

MENTAL HEALTH /DEVELOPMENT REFERRAL FORM

Child/Youth's Name:	Date of Birth:	Gender:

Address: _____

Street City Postal Code

Phone: _____

Primary Contact (for scheduling service)

Name: _____ Relationship to child/youth: _____

Phone: _____ Alternate Phone: _____

Email Address: _____

Reason for Referral (current needs, symptoms, behaviors):

Current Risk Factors

Risk of Harm to Self? ☐ Yes ☐ No

Risk of Harm to Others? ☐ Yes ☐ No

Has the youth met with a mental health professional? ☐ Yes ☐ No

Has a safety plan been completed? ☐ Yes ☐ No

Please provide details of this plan (please attach any relevant documentation)

Referral Source

Name:

Phone number:

Consent to share information? ☐ Yes ☐ No (if yes please attach)

Parent and Child/Youth in agreement with referral? ☐ Yes ☐ No