

Referral Form

Client Information:

Name: _____ Gender Identity _____

Address: _____

City/Town: _____ Province: _____ Postal Code: _____

Telephone: Home _____ Work _____ Mobile _____

Best time to Contact: Morning Afternoon

Best Contact Number (8:30am- 4:30pm): _____

Consent to Leave a Message: Yes No

Email Address: _____

Date of Birth (mm/dd/yy): _____ School: (if relevant) _____ Grade: _____

First Language Spoken: Home _____ School (if different from home) _____

Family Doctor: _____

Food Allergies: _____ Current Medications: _____

Parent/Guardian/Next of Kin Contact Information:

Please check: Mother Father Partner Other: _____

Name: _____

Address: (if different from above) _____

City/Town: _____ Province: _____ Postal Code _____

Telephone: Home _____ Work _____ Mobile _____

If the referred is under age 16, who has legal custody? _____

Do the custodial parent(s)/ guardian agree with the referral? Yes No

Referral Source:

Please check if Self-referral If external referral, please complete:

Name:

Address:

City/Town:

Province:

Postal Code:

Telephone:

Fax Number:

Have you discussed the referral with the family? Yes No

Reason for Referral – Check as appropriate:

- Psychological Assessment Psychosocial/ Diagnostic Assessment
 Therapy Other: _____

Details:

Has the client sought help for this problem before? Yes No

If yes, what services were received & how well did they work?

Are there other agencies involved (past or present) (e.g., Pathways for Children & Youth, Children's/ Adult Mental Health Agencies, Family & Children's Services, Counselling Services)?

Please specify:

Additional Comments:

Please return completed forms to:

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psycclin@queensu.ca