

The Children, Youth and Families (CYF) Addiction and Mental Health Psychiatry Consult Service offers CanREACH Physicians telephone advice and/or consultation service from a Child Psychiatrist.

If you are seeking to refer a client for mental health intervention at one of our CYF community clinics, this is **not** the correct form. To refer to CYF community clinics use the following form: <https://www.albertahealthservices.ca/frm-21396.pdf>

This is not a Crisis Service. If you believe this child/youth is at imminent risk, call the Children's Mental Health Crisis Team in Edmonton at 780-407-1000 or ask the family to go to their nearest emergency room.

Referral Criteria:

- The child or youth must be between the ages of 5 (or in Kindergarten) and 17 years old
- Patient is not already connected to a AHS mental health clinic
- A referral to AHS mental health clinics is not possible or indicated (e.g. client has a private therapist)
- **Referral is made by a CanREACH trained Physician**
- Referral is requesting psychiatry advice or consult for diagnostic clarification and/or medication management. Request is related to a moderate to severe mental health concern.
- There has been at least one medication trial initiated.
- If appropriate, options for therapy have been discussed with the client/caregivers.
- **How to refer:**

Please fax completed referral forms to CYF Central Intake. FAX: (780) 413-4728. For more information, please call: (780) 342-2701.

Date:

Referring Source:

Referring Physician: _____ PRAC-ID: _____

Clinic Name and Address: _____

Phone number: _____ Fax number: _____

Expectation of Referral

- Telephone/Psychiatrist Advice only
 - Best way to reach you: _____
- Patient Consult Short-term management
 - If requesting patient visit, please ensure the family is aware of this referral

Client Information:

Client Name: _____

Date of Birth: _____ PHN: _____

Gender: Male Female Other _____

Address: _____

City: _____ Postal Code: _____ Phone number: _____

Parent(s) or Guardian(s):

Name: _____ Name: _____

Relationship to client: _____ Relationship to client: _____

Phone number: _____ Phone number: _____

Guardianship concerns: _____

PGO/Custody agreement in place? Yes No If yes, please attach.Interpreter required for the appointment? Yes No

If yes, what language: _____

Referral Information:

1. Reason for Referral or Physician's Question:

2. Clinical Impression:

3. Current symptoms and level of risk:

4. Current medications/supplements:

5. Previous treatments and outcomes to date:

6. Current and/or Previous Mental Health Supports

*If seeking psychotherapy, please use the following referral form**<https://www.albertahealthservices.ca/frm-21396.pdf> and send to centralized intake.*

7. Brief Medical History:

Current physical exam and bloodwork? Yes No

8. Substance use (drugs, cannabis, tobacco, alcohol, internet, gambling):

9. Impression of family system:

10. Social (activities, engagement, friends):

11. School concerns:

School: _____ Grade: _____ Program: _____

12. Assessments or Previous testing:

Speech/Language OT Psychoeducational Testing

Screening Tools Other _____

Please attach reports or provide brief summary

Additional Comments:
