Children, Youth and Families Addiction and Mental Health Edmonton Zone
Psychiatry Consulation Services for CanReach Physicians External Referral Form

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:

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