# 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) 408-8776. For more information, please call: (780) 342-4415.

**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:
_____
_____
_____