Alberta Health Services

Children, Youth and Families Addiction and Mental Health Intake Services (Edmonton Zone)

Children, Youth and Families Addiction and Mental Health Intake Services is **not** a Crisis Service. If you believe this child/youth is at imminent risk, call the Children's Mental Health Crisis Line at 780-427-4491 in Edmonton, or your local crisis line.

Is a Psychiatrist involved? □ yes □ no If yes, Internal Referral is required. Please go back to your psychiatrist to request an Internal Referral.

Send completed referral by **Fax** to **780-413-4728** or by **mail** to: Children, Youth and Families Addiction and Mental Health Intake Services, 2020, 9499 - 137 Avenue Edmonton, AB T5E 5R8. For information please **call** 780-342-2701.

As part of the referral process, a legal guardian or mature minor will be asked to participate in a telephone interview that will take approximately 60 minutes. Please indicate name and phone number of person to contact.

Name _____ Phone # _____.

Date *(yyyy-Mon-dd)*	Referred by			
Phone	Fax	Relationship to child/youth	Signature	
Name of child/youth *(first)*		*(middle)*	*(last)*	
Other names child/youth is known by				
Address of primary residence			Phone	
City	Province		Postal Code	
Personal Health Care Number	Date of Birth *(yyyy-Mon-dd)*		Age	☐ Male ☐ Female
Grade	School			

Legal guardian(s)

First name	Last name	Relationship to child/youth	Phone *(home)*	Phone *(cell/work)*
First name	Last name	Relationship to child/youth	Phone *(home)*	Phone *(cell/work)*

Current legal status *(note: documents may be requested)*
☐ Joint custody ☐ Sole custody ☐ Custody not yet established

Who lives in the child/youth's home:

All legal guardians are aware of and in agreement with referral ☐ Yes ☐ No	Language(s) spoken at home

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Reason for Referral/Current Concerns		
What are your expectations of treatment? Are you requesting a specific service, program, clinic, etc?		
Are school supports involved with this child/youth? *(eg., speech/language/OT/PT, consulting services)* ☐ No ☐ Yes		
Has any psychological testing been done on this child? ☐ No ☐ Yes If yes, please attach reports		
Physician/Pediatrician		
Name		
Phone	Fax	Doctor is aware of referral ☐ Yes ☐ No
Medication, Vitamins, Herbal Supplements		
Allergies		

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Current Agencies or Services Involved	Phone	Fax

Child and Family Services Status ***(if applicable)***

- ☐ Assessment in process
- ☐ Enhancement Agreement
- ☐ Supervision Order
- ☐ Custody Agreement
- ☐ Temporary Guardianship Order
- ☐ Permanent Guardianship Order
- ☐ Secure Services

Young Offender's Status ***(if applicable)***

- ☐ Charges Pending
- ☐ On Probation
- ☐ Alternate Measures
- ☐ Court appearance scheduled on _____

Psychiatric/Medical/Developmental History ***(please attach relevant documents)***

Previous Services Accessed *(please attach relevant documents)*

- ☐ Child Psychiatrist
- ☐ Inpatient Programs at Glenrose
- ☐ Day Program at Glenrose
- ☐ Glenrose Clinic
- ☐ Inpatient Programs at the Royal Alexandra Hospital
- ☐ School-Aged Neurodevelopmental Assessment Clinic (SNAC)
- ☐ Preschool Assessment Services (PAS)
- ☐ Mental Health Clinic
- ☐ CASA Programs
- ☐ Addictions Services
- ☐ PCHAD (Protection of Children Abusing Drugs)
- ☐ Residential Care
- ☐ Play/Individual/Family Therapy
- ☐ School Based Services
- ☐ Preschool Program
- ☐ Child and Family Services
- ☐ Family Supports for Children with Disabilities
- ☐ Mental Health Youth Diversion
- ☐ Youth Community Support Program
- ☐ Any Other Services

Additional Comments

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