Primary Care Network WESTVIEW

Youth Mental Health Clinic (YMHC)
Youth Ages 11-25
Referral/Request for Services

Date of Referral: _____

Referred By: _____ Organization/Clinic _____

PATIENT INFORMATION (or demographic label)

Last Name: _____ First Name: _____

Gender Identity: _____ Preferred Pronouns: _____

DOB: _____ AB Personal Health #: _____

Address: _____ City & PC: _____

Email Address: _____ Patient Phone #: _____

Parent/Guardian Name & Phone #: _____

Is patient aware of referral? ☐ Yes ☐ No Family Physician: _____

CONTACT PREFERENCE

□ contact the **parent or guardian** for appointment
□ contact the **patient directly** for appointment

Is the patient connected to any other social or mental health services in the community?

☐ Yes ☐ No If yes, who/where: _____

Are there any other pending mental health referrals we should be aware of? ☐ Yes ☐ No

If yes, where? _____

****Please attach any previous mental health consults or psychoeducational assessments****

Clinical Concern(s):

_____
_____
_____

Current Medications:

_____
_____
_____

Are there any custody or court orders that we should be aware of? ☐ Yes ☐ No