



**Referral Form**

Name of child/adolescent: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Name(s) of parent/guardian:

\_\_\_\_\_ Relationship to child: \_\_\_\_\_

\_\_\_\_\_ Relationship to child: \_\_\_\_\_

Address: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Current medications: \_\_\_\_\_

Presenting concerns (if multiple, please circle the most pressing concern):

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Adjustment to medical illness | <input type="checkbox"/> Anxiety/worry/panic                                     | <input type="checkbox"/> Behavioural problems |
| <input type="checkbox"/> Depression/mood concerns      | <input type="checkbox"/> Encopresis  | <input type="checkbox"/> Enuresis             |
| <input type="checkbox"/> Grief/loss                    | <input type="checkbox"/> Habit concerns (e.g., tics, hair pulling, skin picking) |   |
| <input type="checkbox"/> Needle phobia                 | <input type="checkbox"/> Obsessions/compulsions/OCD                              | <input type="checkbox"/> Pain                 |
| <input type="checkbox"/> Parent-child conflict         | <input type="checkbox"/> Parenting   | <input type="checkbox"/> Sleep problems       |
| <input type="checkbox"/> Treatment adherence           | <input type="checkbox"/> Other (describe): _____                                 |   |

Additional information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Referred by: \_\_\_\_\_ GP: \_\_\_\_\_

Other health care professionals involved: \_\_\_\_\_

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**Please fax referral and relevant documents to (604) 264-1725.**

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