REFERRAL AND INTAKE FORM

REFERRAL SOURCE:	
DEMOGRAPHIC INFORMATION	
Client Name:	
PHIN (nine digit):	
__ __ __ __ __ __ __ __ __	
MHSC (six digit):	
__ __ __ __ __ __	
Date of Birth	
___ _____ _____ **Day Month Year**	
Treaty Number:	
Address:	
Street: City/Town: Postal Code:	
Phone Number:	
	May we leave a voicemail regarding appointments (please circle)? **Yes or No** Signature: Date:
Legal Guardian:	
Name:	
Name of Guardian Agency:	
Guardian Status (if other than parent):	
	Please Circle one: Voluntary Placement Under Apprehension Permanent Ward Temporary Ward
CFS Worker:	
Name:	Phone:
Mental Health/Other Agency Involvement:	

Name:	Phone:
Parent Information:	
Name: Phone Number:	Please circle one: Biological Adopted Foster Step
Parental Status (please circle one):	
Married Divorced Widowed Separated Other	
Child Lives with:	
Please list the name and relationship of those who live in the house: 1. 2. 3. 4. 5.	
Family Physician:	
Name:	Phone:
Allergies (please list):	
• • • •	
Medications:	
Name Dose 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____	
Previous Diagnosis:	