Prince George Community Referral
Child and Youth Mental Health Services

Referral Date: _____

Referral Agency: _____

Primary Contact Person: _____ Position: _____

Phone: _____ Email: _____

Fax: _____

Child/Youth Requesting Service:

Surname: _____ First Name: _____

Preferred Name: ☐ Same ☐ Other: _____

Age: _____ DOB: _____ Gender: _____

Aboriginal Ancestry: ☐ No ☐ Yes: Nation: _____

**Aboriginal and Non Aboriginal children and youth can access either CYMH agency

Parent/Guardian Information (Guardian Accompanying Child/Youth today)

Surname: _____ First Name: _____

Custody/Access: ☐ Sole Guardianship ☐ Joint Custody ☐ Child/youth lives with

Street Address: _____ Postal Code: _____

Phone: _____ Email: _____

Preferred method for initial contact: ☐ Phone ☐ Email

Other Guardian (if Applicable)

Are they aware this referral is being made? ☐ Yes ☐ No: why? _____

Surname: _____ First Name: _____

Custody/Access: ☐ Sole Guardianship ☐ Joint Custody ☐ Child/youth lives with

Street Address: _____ Postal Code: _____

Phone: _____ Email: _____

Preferred method for initial contact: ☐ Phone ☐ Email

Presenting Issues; Reason for Referral:

_____

_____

_____

_____

_____

_____

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What services are the child/youth/family requesting? _____

_____

_____

Other Professionals/Agencies Providing Service to Child/Youth/Family: _____

_____

_____

Are there any special service considerations we should be aware of to support this family? (eg barriers, fears, disabilities etc) _____

_____

Are there any health care needs we should be aware of? (Allergies, diagnosis, medication, recent hospitalization) _____

_____

Are relevant consults and/or documentation attached to this referral? ☐ No ☐ Yes ☐ To Follow

Is there any additional information we should be aware of at this time? _____

_____

I/We support and acknowledge this referral has been made to the ☐ Aboriginal Child & Youth Wellness Program (PGNFC) **OR** the ☐ Child and Youth Mental Health Program (Intersect) on behalf of _____. I am aware that your services are entirely voluntary and that you will contact me when you receive this referral, but it is my responsibility to follow through with accessing services.

_____	_____	_____
Child/Youth (if capable)	Parent/Guardian (if applicable)	Parent/Guardian (if applicable)

Witness/Referral Source: _____ Date: _____

**Aboriginal and Non Aboriginal children and youth can access either mental health agency. Families can choose what agency they would like to be referred to. Please refer to the PG Community Child and Youth Mental Health services document for additional agency information.

Referral to : (select one)	☐ **PGNFC (ACYMH)**	☐ **Intersect (CYMH)**
Fax referral to:	250-614-7727	250-562-4692
Email referral to:	nhc@pgnfc.com	info@intersect.bc.ca
Hours of Operation	Monday to Friday* 8:30-4:30	Monday to Friday* 9:00-5:00
Phone	250-564-4324	250-562-6639
Location	1600-3rd Avenue	1294 3rd Avenue
Website	www.pgnfc.com	www.intersect.bc.ca