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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Intersect Youth & Family Services

Prince George Community Referral
Child and Youth Mental Health Services

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

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____

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

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____

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) **<u>OR</u>** 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:	250-614-7728	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