Child and Youth Mental Health and Addictions Program

Community Health Centre

Intake Form

CHILD/YOUTH INFORMATION:

Name (Last, First, Initial):	Date of Birth (DD/MM/YYYY)	Sex: ☐ Male ☐ Female ☐_____
Address:		
Postal Code:	Telephone (home):	
Family Physician:	Telephone:	
Health Card Number:	Version Code:	
First Nation (if applicable):	Status Card Number (if applicable):	
☐ Aboriginal (status) ☐ Aboriginal (non-status) ☐ Métis ☐ Other		

REFERRAL SOURCE INFORMATION:

☐ Parent/Guardian ☐ Self ☐ Physician ☐ Agency ☐ Other: _____

Name	Address:
Telephone:	Fax:

FAMILY INFORMATION:

Parent/Guardian Name:	Address: (☐ Same as above)		Telephone: (Home): (Work): (Cell):
Parent/Guardian Name:	Address: (☐ Same as above)		Telephone: (Home): (Work): (Cell):
Custody Status: ☐ Joint	☐ Mother	☐ Father	☐ Other (CAS, relative)
Name and ages of siblings who reside in the home (if applicable):			

SCHOOL INFORMATION:

Name of Child/Youth's Daycare/School/Other:		Grade:
School Board:		
Type of Placement: ☐ Regular/Full-time	☐ Not Enrolled	☐ Special Education (specify)

REASON FOR REFERRAL:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Medication:

_____
_____
_____

Allergies: ☐ No☐ Yes If yes, please specify: _____

Known medical conditions and risk factors (e.g., asthma, diabetes, cancer etc.)

_____
_____
_____

OTHER AGENCY INVOLVEMENT:

Please list all other agency involvement (current and on wait-list)

Service Agency	**Outcome**
	☐ Current Involvement ☐ Waitlist
	☐ Current Involvement ☐ Waitlist
	☐ Current Involvement ☐ Waitlist

Completed by:	Date completed: