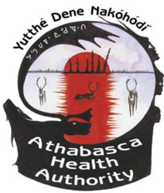

PLEASE FAX FORM TO:
(306) 439-2210

Child Mental Health and Wellness Program
Referral Form

Child's Legal Name Last Name First Name		☐ Male	☐ Female
Birth Date (month/day/year)		Age	Phone Number
Treaty #	**Prov. Health #**		

Parent/Guardian Name	Address	Home Phone Work Phone Email
Parent/Guardian Name (if different from above)	Address	Home Phone Work Phone Email

Family Doctor			**Pediatrician**		
Last Name	First Name	Phone Number	Last Name	First Name	Phone Number

Custody status (**if applicable**)	☐ Sole	☐ Joint	☐ Split	☐ Unknown
Decision making regarding child (**if applicable**)	☐ Sole	☐ Joint	☐ Split	☐ Unknown
Restrictions re Family Involvement with Child.		☐ Yes (attach list of restrictions)		☐ No

SERVICE(S) REQUESTED (please check all that you feel apply)

☐ Speech Language Therapy	☐ 0 to 5 ☐ older	☐ Physiotherapy	☐ 0 to 5 ☐ older
☐ FASD Support Worker	☐ 0 to 5 ☐ older	☐ Occupational Therapy	☐ 0 to 5 ☐ older
☐ Autism/Behaviour Consultant	☐ 0 to 5 ☐ older	☐ Child Mental Health/School Consultation	☐ 0 to 13 yrs
☐ Registered Dietitian	☐ 0 to 5 ☐ older	☐ Play Therapy Clinic/Assessment	☐ 0 to 5 ☐ older

Reason for Referral?

What Do You Hope To Gain From This Referral?

Child referred by	Phone number
Relationship to the child	

Parent/Legal Guardian Signature ______________________________ Date ________________

*(**Parent Consent is MANDATORY** in order to process the referral)*

Date Revised Sept 17/2020

THIS IS NOT AN EMERGENCY SERVICE