Contact NIAGARA
For Children's and Developmental Services
pour les services à l'enfances et d'adaptation

Physician Referral Form

Contact Niagara – The access point for child and youth counselling/psychiatry referral services within the Niagara Region. Our intake process will ensure your referral will be directed to the appropriate services
FAX: 905-684-2728

Patient/Client's Personal Information If client is 16+, are parents aware of referral? Yes ☐ No ☐

Name (incl. Preferred):			Health Card Number :
Address :	City :		Postal Code:
DOB :	Age :	Gender :	Client Phone:
Parent/Contact Name :			Contact Phone :
Parent/Contact Name :			Contact Phone :
Resides with : (Choose)		Custody Type: N/A ☐ Joint ☐ Sole ☐ Unknown ☐	
Family Physician :		Telephone :	
Psychiatrist :		Telephone :	

Referral Information

Referred by :	Date :	Physician's Billing # :

Risks	Within 6 months	Over 6 months ago	None	Unknown		Within 6 months	Over 6 months ago	None	Unknown
Thoughts of suicide:	☐	☐	☐	☐	Thoughts of harm to others:	☐	☐	☐	☐
Suicide attempts:	☐	☐	☐	☐	Engaged in harm to others:	☐	☐	☐	☐
Thoughts of self-harm:	☐	☐	☐	☐	Substance/alcohol misuse:	☐	☐	☐	☐
Engaged in self-harm:	☐	☐	☐	☐	High risk actions:	☐	☐	☐	☐
					Police/legal involvement:	☐	☐	☐	☐

Reason for Request (Required):

Service(s) Requested:
☐ **Counselling/Therapy**
☐ **Psychiatric Consult (for Diagnostic Clarification and/or Medication follow-up)**

Medication **List of Current Medications-Please print clearly**

Name of Medication	Dosage	Frequency
Allergies		

Consent and Agreement

I/, WE (Client/Patient/Guardian) AGREE TO THE EXCHANGE OF INFORMATION BETWEEN
AND CONTACT NIAGARA. I ALSO AGREE TO A RESOURCE COORDINATOR CALLING ME FOR THE PURPOSE OF COMPLETING AN INTAKE.

_____ _____

SIGNATURE DATE