Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg

MENTAL HEALTH AND ADDICTIONS RECOVERY SERVICES

YOUTH MENTAL HEALTH AND ADDICTIONS SERVICE PROVIDER REFERRAL FORM

Client Health Record #
Client Surname
Given Name
Date of Birth
Gender
MFRN
PHIN
Address

** If you have not discussed the referral with the youth/parent/guardian please do not proceed with referral.*

** If the youth is in need of a psychiatric evaluation please do not proceed with referral.*

Referral Date: |_|_|_|_|_|_|_|_| (D D M M M Y Y Y Y)

Preferred Language (if other than English): _____

Referral Source: _____

Interpreter Required: ☐ Yes ☐ No

Youth Chosen Name (if different from above): _____

Youth Pronouns: _____

Youth Phone Number: |_|_|_|-|_|_|_|-|_|_|_|_|

Is the youth a competent mature minor and/or 16+ and capable of consenting for treatment: ☐ Yes ☐ No

** If No, please include contact information for parent/guardian:*

Name: _____

Caregiver Phone Number: |_|_|_|-|_|_|_|-|_|_|_|_|

Please ask the youth the following questions:

Does the youth use any drugs/substances? (e.g. cannabis, alcohol, cocaine, mushrooms, vape, etc.) ☐ Yes ☐ No ☐ Prefer not to answer

Does the youth have any concerns with their mental health? ☐ Yes ☐ No

Details _____

What would the youth like help with? _____

Does the youth have a history or current safety concerns that may impact referral: ☐ Yes ☐ No

If yes, please provide details: _____

Summarize the mental health and/or substance use concerns/issues and presenting problem relevant to current referral

_____

Does the youth have current thoughts/plan of suicide and/or is engaging in self-harming behaviour? ☐ **Yes** ☐ **No**

Details & current safety plan: _____

*** For children/youth call The Link 24/7 crisis line 204-949-4777 or 1-888-383-2776 or the Children's Emergency Department 700 William Avenue*

Provider's reason for referral (check all that apply):

☐ Anger/Aggression	☐ Anxiety	☐ Bullying	☐ Coping with a Medical Condition
☐ Depression	☐ Impulsivity/Hyperactivity	☐ Oppositional Behavior	☐ Recent Loss/Life Change
☐ Relationships	☐ Self Regulation	☐ Sexuality and Gender Identity	☐ Social Media, Gaming Use
☐ Substance Use	☐ Transitioning to Adult	☐ Work/School Stress	☐ Other _____

Special considerations for accessibility (e.g., hearing, mobility), culture or spiritual that the clinician should be informed of?
(e.g. American Sign language (ASL), Teletypewriter (TTY), mobility, etc.) _____

Are there any attachments (i.e. additional documents, assessments) that are attached to this referral? ☐ *Yes* ☐ *No*

If you have any questions regarding appropriateness for service, please call 204-590-6713 / email: WRHAYouthMHAIntake@wrha.mb.ca / Fax: 204-940-3246