Alberta Health Services

Child & Adolescent Mental Health Assessment and Treatment Referral (Edmonton Zone)

Child & Adolescent Mental Health Intake Service is **not** a Crisis Service. If you believe this child/youth is at imminent risk, call the Children's Mental Health Crisis Line at 780-427-4491 in Edmonton, or your local crisis line.

NOTE – If a psychiatrist is currently involved with this child/youth, an internal referral must be submitted by psychiatrist. Please request referral through his/her psychiatrist.

Send completed referral by **fax** to 780-413-4728 or by **mail** to Child and Adolescent Mental Health Intake Services, 2020, 9499 - 137 Avenue Edmonton, AB T5E 5R8. For information please **call** 780-342-2701.

As part of the referral process, a legal guardian or mature minor will be asked to participate in a telephone interview that will take approximately 60 minutes. Please indicate name and phone number of person to contact. Name ______________________ Phone # ______________ .

Date *(yyyy-Mon-dd)*	Referred by		
Phone	Fax	Relationship to child / youth	Signature

Name of child / youth *(first)*	*(middle)*	*(last)*
Other names child / youth is known by		

Address of primary residence	Phone

City	Province	Postal Code	
Personal Health Care Number	Date of Birth *(yyyy-Mon-dd)*	Age	☐ Male ☐ Female

Grade	School

Legal guardian(s)

First name	Last name	Relationship to child / youth	Phone *(home)*	Phone *(cell/work)*
First name	Last name	Relationship to child / youth	Phone *(home)*	Phone *(cell/work)*

Current legal status *(note: documents may be requested)*

☐ Joint custody ☐ Sole custody ☐ Custody not yet established

Who lives in the child / youth's home:

All legal guardians are aware of and in agreement with referral ☐ Yes ☐ No	Language(s) spoken at home

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Reason for Referral / Current Concerns		
What are your expectations of treatment? Are you requesting a specific service, program, clinic, etc?		
Are school supports involved with this child / youth? *(eg., speech/language/OT/PT, consulting services)* ☐ No ☐ Yes		
Has any psychological testing been done on this child? ☐ No ☐ Yes If yes, please attach reports		
Physician/Pediatrician		
Name		
Phone	Fax	Doctor is aware of referral ☐ Yes ☐ No
Medication, Vitamins, Herbal Supplements		
Allergies		

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Current Agencies or Services Involved	Phone	Fax

Child and Family Services Status *(if applicable)*	**Young Offender's Status** *(if applicable)*
☐ Assessment in process ☐ Enhancement Agreement ☐ Supervision Order ☐ Custody Agreement ☐ Temporary Guardianship Order ☐ Permanent Guardianship Order ☐ Secure Services	☐ Charges Pending ☐ On Probation ☐ Alternate Measures ☐ Court appearance scheduled on ____________

Psychiatric / Medical / Developmental History *(please attach relevant documents)*

Previous Services Accessed *(please attach relevant documents)*

- ☐ Child Psychiatrist
- ☐ Inpatient Programs at Royal Alexandra Hospital
- ☐ Inpatient Programs at Glenrose
- ☐ Day Program at Glenrose
- ☐ Glenrose Clinic
- ☐ School-Aged Neurodevelopmental Assessment Clinic (SNAC)
- ☐ Preschool Assessment Services (PAS)
- ☐ Mental Health Clinic
- ☐ CASA Programs
- ☐ Addictions Services
- ☐ PCHAD (Protection of Children Abusing Drugs)
- ☐ Residential Care
- ☐ Play / Individual / Family Therapy
- ☐ School Based Services
- ☐ Preschool Program
- ☐ Child and Family Services
- ☐ Family Supports for Children with Disabilities
- ☐ Youth Diversion
- ☐ Any Other Services

Additional Comments