

Child and Youth Community Services Referral Form

Manitoba Mental Health and Addictions Connect

Last/First Name:

Date of Birth (dd/mmm/yyyy)

Sex:

PHIN:

MB Reg #:

Referral Date

D	D	M	M	M	Y	Y	Y	Y	Y	Y	Y

Referral Source Information

Referral source: <input type="checkbox"/> Primary Care <input type="checkbox"/> Hospital <input type="checkbox"/> Mental Health and/or Addiction Program <input type="checkbox"/> Education System <input type="checkbox"/> Child and Family Services			
<input type="checkbox"/> Justice <input type="checkbox"/> Non-profit Community Organization <input type="checkbox"/> Other:			
Organization / Clinic name:		Role/Designation:	
First name:		Last name:	
Address:			Phone: - -
City:	Province:	Postal code:	Fax: - -

Individual's Information

Name the youth goes by:			
Address:			Individual's phone: - -
City:	Province:	Postal code:	Can we leave message? <input type="checkbox"/> Yes <input type="checkbox"/> No
Preferred contact method: <input type="checkbox"/> Phone <input type="checkbox"/> Text <input type="checkbox"/> Other:			
Gender: <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> Non-binary <input type="checkbox"/> Other:		Pronouns: <input type="checkbox"/> He/Him <input type="checkbox"/> She/Her <input type="checkbox"/> They/Them <input type="checkbox"/> Other:	
If transgender, what name should be used to address postal mail?			
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other:			Interpreter required: <input type="checkbox"/> No <input type="checkbox"/> Yes Language:
Does the legal guardian require an interpreter?: <input type="checkbox"/> No <input type="checkbox"/> Yes Language:			

Individual's Primary Health Care Provider Information (if not referral source)

First name:	Last name:	Clinic phone: - -
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Legal Guardianship Information (if applicable)

Legal guardianship: <input type="checkbox"/> Both parents <input type="checkbox"/> One parent only <input type="checkbox"/> Child protection agency <input type="checkbox"/> Other relative/non-relative <input type="checkbox"/> Youth responsible for self			
Guardian #1	First name:		Last name:
Relationship to individual: <input type="checkbox"/> Legal guardian <input type="checkbox"/> Foster parent <input type="checkbox"/> Other:			
Contact Information (if different from above)			
Address:			Phone: - -
City:	Province:	Postal code:	
Guardian #2	First name:		Last name:
Relationship to individual: <input type="checkbox"/> Legal guardian <input type="checkbox"/> Foster parent <input type="checkbox"/> Other:			
Contact Information (if different from above)			
Address:			Phone: - -
City:	Province:	Postal code:	

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Reason for Referral

Describe current mental health and/or substance use concerns:

What service(s) is/are you looking for? (E.g. psychotherapy, diagnostic clarification, treatment recommendations, Compass admission, etc.)

If this referral is related to a suspected eating disorder, provide height and weight measurements. Height _____ Weight _____

Who is aware of, and in agreement with, this referral request?: Youth only Guardian only Youth and Guardian

Suicide/Self-Harm Assessment

Is the individual currently (or recently had) suicidal/self-harm thoughts?: Yes No If current, please refer to crisis services.

In the past 3 months, has the individual had a) thoughts of self-harm Yes No b) thoughts of suicide?: Yes No

Has the individual ever attempted suicide?: No Yes If yes, approximate date(s):

**If the individual has suicidal/self-harm thoughts, ensure that this is assessed appropriately and access emergency/crisis resources as needed.
Crisis services can be accessed using 988 or the following link: <https://sharedhealthmb.ca/services/mental-health/crisis-services-help-lines/>.**

Mental Health and Substance Use History

Current/previous diagnosis/diagnoses:

Substance(s) used Alcohol Cannabis Hallucinogenics Benzodiazepines Stimulants Opioids Inhalants
(if applicable): Ketamine Misuse of prescription drugs Illicit methadone Other:

Does the individual want help with their substance use?: Yes No

Does the individual want help with their mental health concern?: Yes No

Name of current psychiatrist/psychologist/other mental health or addictions professional (if applicable):

Other relevant treatment services (past or present):

Please attach any relevant reports and/or assessments.

Name of other agencies involved: Children's disABILITY Services Court/Legal matters Other:
 Child & Family Services Probation
 Community Mobilization Program School-based supports

Physical Health

Previous and current diagnosis/diagnoses:

Allergies:

Is the individual pregnant or postpartum?: No Yes If yes, expected date of birth or date of delivery

D	D	M	M	Y	Y	Y	Y		

Current Medications:

Takes medications as prescribed?: Yes No If no, please explain:

Completed by:

Click to Clear Form

PRINTED NAME AND DESIGNATION

SIGNATURE

Toll-free Phone: 1-877-710-3999

Toll-free Fax Number: 1-888-601-0704

TTY Toll-free phone: 1-888-901-0073