EARLY CHILDHOOD MENTAL HEALTH PROGRAM
4325 Neill Street, Port Alberni, B.C. V9Y 1E5
Phone: 250-723-1141 Fax: 250-723-7349
E-Mail: khilmoe@outreachtherapy.org

REFERRAL FORM

_____, _____ ____ ____
(Legal Last Name) (First Name) M F

Birthdate: _____ / _____ / _____
Day Month Year

Parents: _____ *Legal Guardian:* _____
_____ *(if applicable)*

Address: _____ *Address:* _____

City: _____ *City:* _____

Postal Code: _____ *Postal Code:* _____

Telephone: _____ *Telephone:* _____

Alternative: _____

Family Physician: _____

Other services and/or professionals involved with your child (past and present): _____

_____

Preschool, Daycare, or School attending, if any: _____

REASON FOR REFERRAL: (Please give a brief description of your concerns. Continue on back of sheet if more room is needed.)

_____

_____

_____

_____

Has Parent Been Informed of Referral? Yes ____ No ____

Okay to Leave Message on Parent Answering Machine? Yes ____ No ____

Referred by: (please print) _____

Date of Referral: _____

Signature: _____ Agency: _____
(eg. Parent, MD, PHN, SW, etc.)

Address: _____ Telephone: _____