Kelowna Hub Community Referral Form
Integrated Health Solutions Team Date: _____

Parent/Guardian Information

Parent/Guardian Name**:** _____ Address**:** _____

Phone Number**:** _____ Email: _____

Preferred method of contact: _____

Parent signature for Consent to Release Information: _____

Fax the referral C/O of Eileen Smith to (250) 765-7710

Child's Information **Does the child identify as being of aboriginal ancestry?** ◯ **Yes** ◯ **No**

Child's Name**:** _____ Date of Birth: _____ Age: _____

Grade: _____ School: _____ Health Care Number: _____

ASQ offered? ◯ Yes ◯ No Completed? ◯ Yes ◯ No Attached? ◯ Yes ◯ No

ASQ/ SE offered? ◯ Yes ◯ No Completed? ◯ Yes ◯ No Attached? ◯ Yes ◯ No

Comments/referrals**:**_____

_____

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_____

Please list symptoms noticed/behaviors of concern:_____

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If any assessments have been done, please list, and attach if available: _____

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_____

Referred by:_____

Physician Information

Does the child have a family doctor? ◯ Yes (please complete information below) ◯ No

Doctor Name: _____

Doctor's Office Phone Number: _____Doctor's Office Fax Number: _____

Child and Youth Mental Health

Is/has the child been, linked with CYMH **in the past**: ◯ Yes ◯ No &/ or **currently**: ◯ Yes ◯ No

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To be completed by Interior Health Representative

Public Health Nurse Associated with referral: _____

Public Health Nurse Assessment:

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Referral to Nurse Practitioner? ◯ Yes ◯ No (Remember to include RAHC Primary Care Clinic Referral form)

Nurse Practitioner Assessment:

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Referral to CYMH - ◯ Yes ◯ No

Referral to Pediatrician - ◯ Yes ◯ No