

**REFERRAL TO CONTACT HAMILTON**

- I have the consent of the parent/guardian and/or youth (mandatory if over 16) to make this referral.
- The client prefers services provided in French.

NAME OF CHILD/YOUTH: \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ D.O.B. (y/m/d): \_\_\_\_\_

PRIMARY CONTACT: \_\_\_\_\_ PHONE: \_\_\_\_\_

PRIMARY EMAIL: \_\_\_\_\_ CONTACT BY: PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

REFERENT: \_\_\_\_\_ PHONE/EMAIL: \_\_\_\_\_

AGENCY/POSITION: \_\_\_\_\_

<b>Risk Presentation:</b>	<b>Today</b>	<b>Last 30 Days</b>	<b>Historical</b>	<b>N/A</b>	<b>Unknown</b>
Homicidal Ideation with plan	<input type="checkbox"/>	<input type="checkbox"/>			
Homicidal Ideation without plan					
Suicidal Ideation with plan					
Suicidal Ideation without plan					
Suicide Attempt					
Family or Placement Breakdown					
Significant Aggression					
Symptoms of Psychosis/Mania					
School Refusal					

PRESENTING CONCERNS / SERVICES INVOLVED / COMPLETED ASSESSMENTS:

Please attach any documentation that may support this referral. Thank you  
**PLEASE FAX COMPLETED FORM TO 905-522-5998**