**For Youth aged 16-24**

**Fax** Referrals to 519-751-5548 **OR Email** Referrals to [mhreferrals@bchsys.org](mailto:mhreferrals@bchsys.org)

**Referring to**

Self Esteem Group 2pm (September 11-October 23)

Focus & Thrive Group 2pm (August 7- September 4)

Foundational Skill Building Group (First Thursday of the month August 7, September 4, October 2, November 6, December 4)

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| --- | --- |
| Referral Source Information | |
| Is this a Self-Referral □Yes | |
| Referring Agency |  |
| Referring Name |  |
| Phone Number |  |
| Fax Number |  |

|  |  |  |
| --- | --- | --- |
| Client Information | | |
| First Name |  |
| Last Name |  |
| Birthdate (D/M/Y) & Age |  |
| OHIP # |  |
| Address |  |
| (Street name, number postal code, city and province) |  |
| Direct Phone # |  |
| Email |  |
| Preferred Pronouns |  |

Client aware of and / or agrees with referral? □Yes □No

Can a confidential message be left on clients voicemail? □Yes □No

Family Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychiatrist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_