YOUTH Group Referral

Outpatient Mental Health & Addiction Services

For Youth aged 16-24

Fax Referrals to 519-751-5548 **OR Email** Referrals to mhreferrals@bchsys.org

Referring to

☐Self Esteem Group (May 19-June 30)
☐Focus & Thrive Group (April 10- May 8)
☐Coping with Chronic Pain Group (May 22- July 17)
☐Foundational Skill Building Group (April 7- April 28)

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: _____