White Buffalo
Indigenous Urban Services

517 A Tranquille Road, Kamloops, BC V2B 3H3
Tel: 250-554-1176 / Fax: 250-554-1157

Aboriginal Child and Youth Mental Health (ACYMH) Referral Form

Please complete this form and fax to ACYMH Wellness Coordinator at 250-554-1157.

REFERRAL INFORMATION

Referral Source: _____ **Referral Date:** _____

Child/Youth Being Referred: _____ ☐ **F** ☐ **M** ☐ **Other** **D.O.B:** _____

Child/Youth Address: _____

Client Home Tel: _____ **Client Cell:** _____

Can a message be left at this number? ☐ Y ☐ N **Can a message be left at this number?** ☐ Y ☐ N

ABORIGINAL INFORMATION

Identify: (check all that apply)

☐ **Mètis** ☐ Non-Status ☐ Status ☐ **First Nation** ☐ Non-Status ☐ Status ☐ **Inuit**

Band/Community: _____

CAREGIVER INFORMATION (enter all applicable information)

Birth Mother: _____ **Tel:** _____

Address: _____

Birth Father: _____ **Tel:** _____

Address: _____

Caregiver: (if not parents) _____ **Tel:** _____

Relationship to child/youth: (i.e. foster parents, grandparents, etc.) _____

Address: _____

CAREGIVER INFORMATION (...continued)

With whom does the child/youth reside?

Who is the child/youth's guardian?

Identify any concerns with access to/involvement of biological family:

Had the parent/legal guardian consented to this referral? ☐ Yes ☐ No

(Parental/guardianship consent must be given to commence service for children under 12)

MINISTRY INVOLVEMENT (if applicable)

Social Worker: **Agency:**

Office Location: **Tel:**

The child/youth is in care via: (check one)

☐ Voluntary Care Agreement ☐ Temporary Custody Order ☐ Continuing Custody Order

This youth is on a: (check one)

☐ Independent Living Contract ☐ Youth Agreement Order

The child/youth is in custody of:

SUPPORT INFORMATION

School/Daycare:

Contact Name: **Tel:**

Other professionals currently involved: (indicate name, position and phone number)

Significant personal relations for the child/youth:

What other supports do you think parents/caregivers or the child/youth need?

MEDICAL INFORMATION

Physician Name: **Tel:** **Fax:**

Psychiatrist Name: **Tel:** **Fax:**

Pediatrician Name: **Tel:** **Fax:**

Diagnosis: (include dates of diagnosis and by whom diagnosis was made)

Assessments: (include dates of assessments and who completed the assessments)

Medications that the child/youth is taking:

1.

2.

3.

ADDITIONAL INFORMATION

Child/Youth's Strengths:

Child/Youth's Extracurricular Activities:

REASON FOR REFERRAL

Identify Specific Challenges: (check all that apply)

- ☐ Suicidal
- ☐ Self-Harm
- ☐ Depression
- ☐ Recent Trauma Event
- ☐ Violent or Aggressive Behaviour
- ☐ Obsessive Compulsive
- ☐ Anxiety

1. Provide basic information regarding the child/youth's situation including presenting concerns.

2. Please explain how the presenting concerns are impacting their participation in school and/or other social activites?

3. Identify the preferred focus of service (what specifically you would like the clinician to support the youth/child with).