CHATHAM KENT CHILDREN'S SERVICES
495 Grand Avenue West
Chatham, Ontario N7L 1C5
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MENTAL HEALTH /DEVELOPMENT REFERRAL FORM

Child/Youth's Name:	**Date of Birth**:	**Gender:**
Address: _____ **Street** **City** **Postal Code** **Phone:** _____		
Primary Contact (for scheduling service) **Name:** **Relationship to child/youth:** **Phone:** **Alternate Phone:** **Email Address:**		
Reason for Referral (current needs, symptoms, behaviors):		
Current Risk Factors: **Risk of Harm to Self? Yes No** **Risk of Harm to Others? Yes No** **Comments:**		
Referral Source: **Name:** **Phone number:** **Consent to share information? Yes No (if yes please attach)** **Parent and Child/Youth in agreement with referral? Yes No**		