YOUTH Group Referral

Outpatient Mental Health & Addiction Services

For Youth aged 17-25

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

REFERRING TO

☐Self Esteem Group | Mondays at 5pm (October 5- November 9)

☐Focus & Thrive Group | Mondays at 5pm (February 8 – March 15)

REFERRAL SOURCE INFORMATION

Is this a Self-Referral ☐ Yes ☐ No

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 client's voicemail? ☐ Yes ☐ No

Family Physician: _____ Phone: _____

Psychiatrist: _____ Phone: _____