F A X

From: London Health Sciences Centre
To: CRISIS INTAKE TEAM (CIT)
(Craigwood / Vanier / WAYS Mental Health Support)

Do Not Stamp
Addressograph

Fax: 519-433-1302 Attn: Sandy Dobaczewski CIT #:_____

Referral Form: Mental Health & Addictions Children and Youth for London-Middlesex Only

Please print all entries. LHSC Referring Person:_____

Patient Name:_____ Date of Birth:_____ Gender: M / F / Other

Parent / Guardian:_____ Primary Care Dr:_____

Patient Phone Contact	Preferred: _____	**Can we leave a message?** ☐ Yes ☐ No
	Other: _____	**Can we leave a message?** ☐ Yes ☐ No
Parent/Guardian Phone Contact	Preferred: _____	**Can we leave a message?** ☐ Yes ☐ No
	Other: _____	**Can we leave a message?** ☐ Yes ☐ No
Agencies Involved with Patient	☐ CPRI	☐ Justice Services ☐ OECYC
	☐ ADSTV	☐ Vanier/Craigwood/WAYS ☐ None
	☐ LHSC: _____	☐ Other: _____
Preferred Language	☐ English ☐ French	☐ Other: _____

REQUIRED: Consent from Patient / Parent / Guardian to make the referral and to release the patient's personal health information

☐ Yes I agree to have the below referral information released to the Crisis Intake Team

☐ No Referral declined by patient/parent/guardian

Patient/Parent/Guardian Signature: _____ Date:_____

Clinician Signature: _____ Date:_____

Reason for Referral:

Please fax additional assessment or recommendation documents if available.