To: Youth Outreach Mental Health Service
Fax number: 905-688-5108

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<h1>REFERRAL FORM</h1>

Youth Outreach Mental Health Service
145 Queenston St., Suite 100
St. Catharines, Ontario L2R2Z9
Phone: 905-688-2558 Ext. 252
Fax: 905-688-5108
</td>
<td>Date:</td>
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<td>
Client Name: Pronouns:
Contact Number:
(specify if client's # or someone else's)
Email Address:
Address:
City: PC:
Date of Birth (MM/DD/YYYY):
Health Card #: Exp:
Secondary Contact:
*If client has No Fixed Address please indicate where we may look for client in community (e.g. name of shelter, WMS, safe beds, SMUN)
*Please specify if possible, if primary contact prefers text or phone call
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Referring Agency:
Contact Person:
Phone Number:
Fax Number:
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1) Which priority populations apply to the client (check all that apply)?

- ☐ 12 – 25 years of age *(Required)*
- ☐ Persistent Mental Health Concerns
- ☐ Substance Use/Addiction Concerns
- ☐ 2SLGBTQ+
- ☐ Homeless/Housing Concerns
- ☐ Low income

2) Does this client have a primary care provider? **YES** ☐ **NO** ☐
If yes, who: ____

3) Has client consented to / aware of referral: **YES** ☐ **NO** ☐

4) Reason for referral:
____
____
____

5) Safety Concerns: ____
____
____
____

6) Organizations known to be involved with client: ________________________
____
____
____