



**CHILD & ADOLESCENT MENTAL HEALTH SERVICES**  
**Addiction and Mental Health – Edmonton Zone**  
**Northgate Assessment and Treatment Services**

Northgate Health Centre  
 2020, 9499 – 137 Avenue  
 Edmonton, AB T5E 5R8  
 Phone: 780-342-2701 Fax: 780-413-4728

DATE: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 (if other than parent/guardian)

Signature: \_\_\_\_\_ Profession: \_\_\_\_\_

NAME OF CHILD: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 (First) (Middle) (Last)

Other Names Child is known by: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ Prov: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Health Care Number: \_\_\_\_\_ D.O.B: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_ Male  Female   
Day Month Year

Grade: \_\_\_\_\_ School: \_\_\_\_\_

Parent / Guardian: (please indicate relationship to child / youth) \_\_\_\_\_

Name: \_\_\_\_\_ Phone: (H): \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Name: \_\_\_\_\_ Phone: (H): \_\_\_\_\_ (W): \_\_\_\_\_ (C) \_\_\_\_\_

Who else lives in the house? \_\_\_\_\_

Would you describe this child as: First Nations Non Status  First Nations Status  Metis  Inuit   
 Other \_\_\_\_\_ N/A

Language(s) spoken at home other than English: \_\_\_\_\_

FAMILY PHYSICIAN / PEDIATRICIAN: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Is Doctor Aware of Referral? Yes  No

CURRENT AGENCY or SERVICES INVOLVED: (Name and Title)	Phone	Fax

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**REASON REFERRED / CURRENT CONCERNS:**

Physicians, parents, other service providers, please record your concerns here.

What are your expectations of treatment? (Are you requesting a specific service, program, clinic, etc.?)

Is there *current* involvement of a psychiatrist?  Yes  No If Yes, Name: \_\_\_\_\_

Has there been *previous* psychiatrist involvement?  Yes  No If Yes, Name: \_\_\_\_\_

Have school supports (e.g., speech / language / OT /PT, consulting services) been involved with this child?  Yes  No

Has any psychological testing been done on this child?  Yes  No *(Please Attach Reports)*

**PSYCHIATRIC / MEDICAL / DEVELOPMENTAL HISTORY:** (Please record or attach relevant information and reports.)

**MEDICATIONS:** (Please record or attach relevant information) (Please include past medications, if known, and any reactions.)



*This referral is part of access to all publicly funded Children's Mental Health services. In accordance with the requirements of the Health Information Act, authorization to collect individually identifying health information from sources other than the guardian of the child or the child is required. The authorization must be provided from the guardian of the child or, from the child directly if he or she understands the nature of the right or power and the consequences of exercising the right or power ("mature minor").*

**AUTHORIZATION:** *In order to determine what services your child requires, we request your permission to contact your child's school / preschool or other service providers if required.*

**PARENT / GUARDIAN:** Please print

I, \_\_\_\_\_, parent /guardian of \_\_\_\_\_ consent and authorize Children's Mental Health (pursuant to section 22(2)(a) of *the Health Information Act*, to collect in accordance with sections 20(b) and 21(1)(a) of HIA, any individually identifying health information that the school or other services providers may have regarding my child's school or other functioning or development, including written reports on the above-named child/adolescent.

\_\_\_\_\_  
(Signature of guardian)      Phone: \_\_\_\_\_      Date: \_\_\_\_\_

\_\_\_\_\_  
(Signature of witness)      \_\_\_\_\_  
(Printed name of witness)      Date: \_\_\_\_\_

**Or**

**MATURE MINOR:**

I, \_\_\_\_\_  
(Printed Name) authorize the Children's Mental Health (pursuant to section 22(2)(a) of *the Health Information Act*, to collect, in accordance with sections 20(b) and 21(1)(a) of HIA, any of my individually identifying health information and registration information from school or other services involved in my care.

\_\_\_\_\_  
(Signature of mature minor)      Phone: \_\_\_\_\_      Date: \_\_\_\_\_  
(If different than above)

\_\_\_\_\_  
(Signature of witness)      \_\_\_\_\_  
(Printed name of witness)      Date: \_\_\_\_\_

Child & Adolescent Mental Health Intake Service is not a Crisis Service.

If you believe this child is at Imminent Risk, call the Children's Mental Health Crisis Line at 780-427-4491 in Edmonton, or your local crisis line.

**PLEASE NOTE: (Attach any relevant reports to the completed intake.)**

- As part of the intake / referral process, the parent or guardian, or the child may be asked to participate in a telephone-screening interview. An intake coordinator will arrange this interview at a time that is mutually convenient for the parent / guardian, and the staff. It will take approximately 45-60 minutes to complete the screening interview.