Ontario
Waterloo Wellington Local Health Integration Network

CHILD AND YOUTH MENTAL HEALTH & ADDICTIONS NURSE (MHAN) REFERRAL

Student Information

Student's Name _____ Phone _____ ☐ Home ☐ Cell

Gender: ☐ Male ☐ Female ☐ Other Patient identifies as First Nations Status ☐ Yes ☐ No

Home Address _____City _____Postal Code:_____

HCN _____ VC _____ DOB _____

Family Physician _____ Psychiatrist_____

☐ Student is in the Care of Children's Aid Society (Child's Aid Society is student's legal guardian)

Languages Spoken in Home ☐ English ☐ French ☐ Other Specify_____

Parent/Guardian Contact Information

☐ Mother ☐ Father ☐ Guardian ☐ 1st Contact

Name _____

Address _____

City _____Postal Code _____

Home # _____Cell#_____

Parent/Guardian Contact Information

☐ Mother ☐ Father ☐ Guardian

Name _____

Address _____

City _____Postal Code _____

Home # _____Cell #_____

Consent for Referral to MHAN program

☐ I give permission to the MHAN program to collect information for the purpose of providing care/services, to share that information with those in the circle of care and to notify my school that I am participating in the MHAN program. No other information will be shared with my school without my informed consent.

School Name _____ City: _____

Verbal Consent for Referral Obtained from the Student ☐ No ☐ Yes Date _____

Verbal Consent for Referral Obtained from Parent/Guardian ☐ No ☐ Yes Date _____

Health Information All patient Medical Notes Attached ☐ No ☐ Yes Medication List Attached ☐

☐ Diagnosis:_____

☐ Allergies:_____

☐ Suicidal Ideation/ attempts ☐ Stressors/Family History specify: _____

☐ Community Agencies Involved with Student:_____

Risk Factors Substance Use: ☐ Alcohol ☐ Nicotine ☐ Other Specify: _____

☐ Daily ☐ Recreational

Mental Health Nursing Role Needs of Student ☐ Transition from Hospital

☐ Medication Concerns/Misuse ☐ Medication changes ☐ MH Health System Navigation

☐ Sleep hygiene ☐ Health Teaching ☐ Nutritional ☐ Other:_____

Goal of Referral:

MHAN Referral Source: ☐ Inpatient **Hospital**: _____ **Discharge Date:**_____

☐ Outpatient Clinic ☐ ER ☐ Pediatrician ☐ Psychiatrist ☐ Family Physician ☐ Other:_____

Contact Name: _____ **Position:** _____ **Phone**: _____

Physician Name: _____ **Signature:**_____ **Date:**_____

Fax this form ALONG with Medical History, Medication list and Collateral information to:

WWLHIN Child and Youth Mental Health & Addictions Fax # 1(519) 571-3957

A WWLHIN Mental Health Nurse will connect with student/family