1Call1Click.ca REFERRAL FORM

Fax: 613-738-4299

Referral Source Information

Referral request made by:	Contact Number:
Address:	
Billing number (if applicable):	Fax Number:
Relation to Child/Youth:	

Child/Youth Information

Name:	Date of Birth:
Health Card Number:	Health Card Expiry Date:
Address:	Cell Number:
Ontario	Home Number:
Sex:	Preferred Pronouns:
Gender Identity:	Specify other gender:

Referral request for:

IF CHILD/YOUTH: Is there consent to contacting caregiver/guardian regarding providing services through 1Call1Click?

IF CAREGIVER: Caregiver Name:

Emergency Contact

Full Name:	Relationship:
Phone Number:	Is legal guardian:

Language(s) spoken at home:	If other, please specify:
In which official language, English or French, would the client like to receive services?	
What is the best way to reach the child/youth/caregiver:	
IF PHONE: Best number to be reached:	
IF EMAIL: Email Address:	

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Please explain why the client is requesting Mental Health and/or Addiction support:

Has the client received Mental Health and/or Addiction services in the past?

IF YES: please provide details:

Does the client consent to meeting with someone to further discuss their needs?
(Consent must be obtained by youth 12+ and deemed capable. Please remind the child/youth that their consent is voluntary and can be withdrawn at any time in this process. Remind the child/youth that this information is kept confidential and is not released without consent, except as required by law.)