# LUCENA CLINIC CHILD AND ADOLESCENT MENTAL HEALTH SERVICE - REFERRAL FORM

## CLIENT CONTACT INFORMATION

Child's name: _____ DOB: ___ /__ /___ Sex: M / F

Mother's name: _____ Father's name: _____

Address: _____ Address: _____

_____ _____

Telephone: _____ Telephone: _____

Consent to referral: Y / N (circle) Consent to referral: Y / N (circle)

Who has legal guardianship of this child/young person: _____

## REASON FOR REFERRAL:

_____

_____

_____

_____

_____

_____

_____

**Relevant additional information:** _____

_____

**Medical History:** _____

_____

**Medication:** _____ **Allergies**: _____

## G.P.'S CONTACT INFORMATION

Name: _____

Address: _____ Phone No: _____

_____ Fax No: _____

_____ Email Address: _____

**Signature of GP:** _____ **Date:** ___ /___ / ___