



### Third Party Referral Form

**Information on the Child/Youth:**

Child/Youth First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Day \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_ Gender: Male  Female  Other : \_\_\_\_\_

Health Card No.: \_\_\_\_\_ Version Code: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Address: \_\_\_\_\_ Apt./Unit # \_\_\_\_\_ Street \_\_\_\_\_ City/Town \_\_\_\_\_ ON \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Child/Youth lives with: Both parents  Mother  Father  Other : \_\_\_\_\_

**Who should be contacted for this referral?**

Child/Youth: Yes  No  If no, who?: \_\_\_\_\_ Relationship to Child/Youth: \_\_\_\_\_

Phone No.: \_\_\_\_\_ Can messages be left? Yes  No

Alternative No. to reach youth: \_\_\_\_\_ Permission to text the youth? Yes  No

E-mail Address: \_\_\_\_\_ Can messages be left? Yes  No

Does this contact person speak English? Yes  No  If no, what language? \_\_\_\_\_

**Referral Source Information:**

Name of Referring Person: \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_

Referring Organization: \_\_\_\_\_

Phone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

Reason(s) for referral (Attach any supporting documents with additional information about child/youth needs):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of Referral: \_\_\_\_\_ Day \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_

**The WhereToStart.ca Consent to Disclose Form must accompany this Third Party Referral Form.**  
Completed Referral Form to be faxed together with Consent Form to WhereToStart.ca at (905) 696-0352 or email info@wheretostart.ca  
WhereToStart.ca Phone No.: (905) 451-4655



## Consent to Disclose Information to WhereToStart.ca

Legal Name of Child/Youth: \_\_\_\_\_  
First Last

Child/Youth Date of Birth: \_\_\_\_\_  
Day Month Year

I, \_\_\_\_\_  
(Full Name of Parent/Guardian or Youth) (Relationship to Child/Youth)

of \_\_\_\_\_ ON \_\_\_\_\_  
Street Address City Prov. Postal Code

give permission for \_\_\_\_\_ to share any relevant behavioral, social, emotional  
(Name of Referring Organization)  
 psychological, psychiatric, developmental and medical information related to the above-named child/youth with **WhereToStart.ca** for the purpose of making a referral for child and youth mental health services and assisting in service planning, No further disclosure of the information is authorized.

This consent is valid for one (1) year from the date written below, unless revoked. I have been informed of my right to revoke this consent at any time by informing the staff of the above-named referring organization or WhereToStart.ca of my decision to do so.

\_\_\_\_\_  
 Signature of Parent/Legal Guardian  
*(not required for youth making self-referrals)*

\_\_\_\_\_  
 Signature of Witness

\_\_\_\_\_  
 Signature of Youth  
*(required if over 16 or making self-referral)*

I also give my permission for **WhereToStart.ca** staff to share information about the status and/or outcome of the referral made on my behalf with the above named referring organization. I understand that I may revoke my permission at any time by informing the staff of the above-named referring organization or WhereToStart.ca of my decision to do so.

\_\_\_\_\_  
 Signature of Parent/Legal Guardian  
*(not required for youth making self-referrals)*

\_\_\_\_\_  
 Signature of Witness

\_\_\_\_\_  
 Signature of Youth  
*(required if over 16 or making self-referral)*

Dated on the: \_\_\_\_\_ of \_\_\_\_\_, \_\_\_\_\_  
Day Month Year

**The WhereToStart.ca Third Party Referral Form must accompany this Consent Form.**  
 Completed Consent and Referral Forms to be faxed together to WhereToStart.ca at (905) 696-0352 or email [info@wheretostart.ca](mailto:info@wheretostart.ca)  
 WhereToStart.ca Phone No.: (905) 451-4655