The Children's Foundation

#1000 (10th Floor) 13737-96 Avenue
Surrey, BC, V3V 0C6

Cedarwood Family Program

Phone: 778-945-1690 | Fax: 778-395-3327

Child & Youth Mental Health (CYMH) Referral Form

www.childrens-foundation.org

Cedarwood Screening Tool for Families from CYMH:

Note: Ask client whatever questions you need to, to determine the likely answer to each item below.
If in doubt, consult with the Cedarwood Clinical Supervisor.
This list reflects CEDARWOOD policy, but exceptions may be warranted.

1. Is child 11.0 years of age or less?	YES☐ NO☐
2. Has behavior problem been going on a long time (e.g., over 6 months)?	YES☐ NO☐
3. Are behavior problems more than a reaction to a specific event/situation?	YES☐ NO☐
4. Are problems likely to threaten the stability of the home or school placement, or the child's wellbeing (but primarily non-protection)?	YES☐ NO☐
5. Have less intensive community helpers been tried, including physician? (For example: school counsellor, CHADD, Parents Together, church, relatives)	YES☐ NO☐
6. Does family have the motivation and the means to attend at least one appointment weekly, usually in Surrey (some day, some evening) for up to 1 year?	YES☐ NO☐

If "YES" to all above, continue:	If **"NO"** to any of the above, refer client back to try less intensive community supports

7. Can the family safely wait for CEDARWOOD services to become available? (CEDARWOOD) is not able to be an emergency service)	YES☐ NO☐

If "YES," then this is an appropriate referral to CEDARWOOD; Refer to Cedarwood by completing the CYMH Referral and fax or email to Cedarwood. Tell client CEDARWOOD staff will call them to confirm referral and when their spot opens. No further MCFD involvement is necessary unless, or until, child protection or major psychiatric issues arise.	**If "NO",** refer to a more rapid-access service.

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Total Pages Faxed: enter text.	Date: enter a date.	
Referring CYMH Worker: enter text.	CYMH Office Code: enter text.	
Phone: enter text.	Fax: enter text.	Email: enter text.
CEDARWOOD First Suggested to Family by: enter text.		

Child Information

Child's Last Name:	Child's First Name:	Gender:	DOB:
enter text.	enter text.	enter text.	enter a date.
Address: enter text.			Postal Code: enter text.
School: enter text.	Grade: enter text.	Phone: enter text.	

Cultural Identity

☐	Arab/West Asian (Armenian, Egyptian, Iranian, Lebanese, Moroccan)	☐	Chinese
☐	Black (African, Haitian, Jamaican, Somali)	☐	Filipino
☐	Indigenous (Aboriginal, Inuit, Metis)	☐	Japanese
☐	South Asian (e.g., East Indian, Pakistani, Sri Lankan)	☐	Korean
☐	Southeast Asian (e.g., Vietnamese, Cambodian, Laotian, Thai)	☐	Latin American
☐	West Asian (e.g., Iranian, Afghan)	☐	White (Caucasian, European)
☐	Other Group: (Please Specify) enter text.		

Family Information

Family Members (Caregivers, Siblings, etc.) Name, First & Last	DOB *(If Known)*	Relationship	Program Involvement	Same Residence	Cultural Identity (from above)
enter text.	enter a date.	enter text.	☐	☐	enter text.
enter text.	enter a date.	enter text.	☐	☐	enter text.
enter text.	enter a date.	enter text.	☐	☐	enter text.
enter text.	enter a date.	enter text.	☐	☐	enter text.

Family Contact 1: name.	Email: enter text.	Cell Phone: enter text.
Family Contact 2: name	Email: enter text.	Cell Phone: enter text.

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Referral Information	
Involved Professionals: enter text.	
Doctor: enter text.	Phone: enter text.
Current Medication: enter text.	
Diagnosis if Known: enter text.	
Current Challenges: (Please be Specific about Nature and Duration of the Concerns) enter text.	
Support Needs (Goals):	
1. enter text.	
2. enter text.	
3. enter text.	
Known Safety Concerns: (e.g. Substance Use, Self-Harm, Suicidal Ideation, etc.) enter text.	
Previous/Current Services (Name of Service & Date): enter text.	
Other Information: (Information Attached?) YES ☐ NO ☐	
enter text.	