Centre intégré universitaire de santé et de services sociaux de l'Estrie – Centre hospitalier universitaire de Sherbrooke
Québec

B Y 1 0 6

Date of birth	File Number	
Health Insurance Number		
Last name at birth	First name	
Address		
City	Postal code	Phone number
Last and first name of mother/legal representative		
Last and first name of father/legal representative		

INSTALLATION : _____

SERVICE REQUEST

PSYCHOSOCIAL INTAKE REFERRAL FORM – FOR PARTNERS

DATE | Year | | | | Month | | Day | |

REFERRAL OF SERVICE REQUESTS FOR THE YOUTH 0-18 AND THEIR FAMILY

Young person experiencing biopsychosocial needs (housing, food, clothing, parental or emotional difficulties, etc.): **Complete and send this form to the psychosocial intake service in your area.**

Young person experiencing suicidal or homicidal thoughts: **Refer to Info-Social at 1-866-APPELLE (1-866-277-3553).**

Young person who is a victim of physical, sexual, or other forms of abuse: **Report to the DPJ at 1-800-463-1029.**

Situation or problem presented: (Describe the problem in the person's living environment(s) that prompted the referral. Precisely describe the behaviours or current situation).

Diagnosis by a qualified professional (if applicable):

FDCU-PSC-004A

User name : _____ File number : _____

Relevant contextual elements related to the problem: (e.g., biopsychosocial factors, loss, bereavement, financial precarity, disability, illness, etc).

Elements of vulnerability and/or risk factors:

☐ Suicidal ideation (if completed, attach the suicide risk assessment grid)	☐ Aggressive/violent behaviours
☐ Homicidal Ideation or thoughts	☐ Homelessness situation/risk
☐ Isolation or lack of support network	☐ Legal problem
☐ Exhaustion of current support network	☐ Academic failure
☐ Significant financial stakes	☐ Significant behavioural/psychological disorganization
☐ Intimidation	☐ Other : _____
☐ Alcohol/drug dependence/gambling: Specify : _____	

Current professional services: (Indicate follow-ups with doctor(s), specialist(s), counsellor(s), etc).

Referent expectations: (Indicate the reason why you are submitting this referral form).

Child/parent/legal representative expectations: (Describe the needs expressed by the user/parent/legal representative)

Instructions for reaching the child/parent/legal representative: (Add any additional contact information and indicate the best time to reach the user/parent/legal representative).

User name : _____ File number : _____

Validated tool evaluation results, if applicable, to be attached: (Evaluation carried out by a professional)

☐ **To the attention of the recipient of this form**: If this box is checked, please contact the referent.

Consent		
As the user (over 14 years old) parent or legal representative of the child, I consent to this form being sent to the psychosocial reception on (date):		
Signature of the user/parent/legal representative	Printed name	Date
☐ Verbal consent obtained on (date): _____		
Signature of the referent	Printed name	Date

Organization	
Referent name	
Adress	
Email address	
Telephone number	

REFERENCE DATE :

Send the form to the following email address (depending on your territory):
☐ Sherbrooke: accueilpsychosocial.sherbrooke.ciussse-chus@ssss.gouv.qc.ca
☐ Memphrémagog: accueilpsychosocial.mm@ssss.gouv.qc.ca
☐ Coaticook: accueilpsychosocial.coaticook@ssss.gouv.qc.ca
☐ Val Saint-François: accueilpsychosocial.vsf@ssss.gouv.qc.ca
☐ Haut-St-François: accueilpsychosocial.hsf@ssss.gouv.qc.ca
☐ Val-Des-Sources: accueilpsychosocial.dessources@ssss.gouv.qc.ca
☐ Granit: accueilpsychosocial.granit@ssss.gouv.qc.ca
☐ Haute-Yamaska: accueilpsychosocial.cssshy16@ssss.gouv.qc.ca
☐ La Pommeraie: accueilpsychosocial.csslp16@ssss.gouv.qc.ca