**Request for services – Équipe psycho-sociale**

Date of referral: _____

Referring Agency □ Professional □ Parent/Caregiver □ Name: _____

Name of client: _____ (0-18 years of age)

Age: _____ Date of birth: _____ Identification: □ F □ M □ OTHER

**Reason(s) for the referral:**

- □ Behaviour (aggressive, oppositional/defiant)
- □ Mental health diagnosis (ADD, ADHA, Anxiety)
- □ Fears, phobias, anxiety
- □ Dysfunctional relationships/conflicts
- □ Addictions
- □ Self-esteem issues
- □ Suicidal thoughts and/or attempts
- □ Self-harm
- □ Eating disorder
- □ Family conflict
- □ Depression/mood
- □ Social issues
- □ School absenteeism
- □ Other: _____

_____

**Parent/caregiver's name**: □ married □ separated/divorced □ other: _____

1. _____ 2. _____

**Address (s) :**

1.
2. _____ 2. _____
   _____ _____
   _____ _____

**Telephone number :**

Home : _____ Home : _____
Work : _____ Work : _____
Cellular : _____ Cellular : _____

I, _____ hereby consent that my child, _____ be referred to l'Équipe psycho-sociale on this day _____ 20___.

Parent/Caregiver with legal guardianship consent: _____

Referring person/Professionnal/Agency: _____

Please fax to (613) 938-8163 or email at eps@equipepsychosociale.ca and our Intake Worker will be in contact with you shortly