MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

Transitional Youth Program (TYP) Referral Form

MRN /

MGH Patient Label

Criteria Ages 16 up to 29 residing in the MGH catchment area:
Bayview Ave. to Midland Ave. & Eglinton Ave. E. to Lake Ontario

Please send referrals by: Fax (416-469-6805) or Email (typ@tehn.ca)

Select One

☐ **Clinical Navigation** ☐ **Peer Support Worker** ☐ **Both Services**

Client Information

Name: ______________________ Age: _____ DOB [mm/dd/yy]: ___________ Pronouns: ________
Address: ______________________ Gender: ________
Email: ______________________ Phone: ______________________
Consent to be contacted by: Phone: ☐Yes ☐No Text message: ☐Yes ☐No Email: ☐Yes ☐No
Emergency Contact: Name/Relationship/Phone ______________________
Family Doctor: ______________ Psychiatrist: ______________ OHIP#: ______________

Referral Source

Name: ______________________ Referral Date [mm/dd/yy]: ______________
Department / Agency: ______________________ Title / Position: ______________
Phone: ______________________ Email: ______________

Reason for Referral

Primary reason for referral (presenting problems, history, symptoms):

What is the discharge plan? What services might be helpful?

Describe any barriers the youth has faced in accessing services:

Agencies involved in past two years:

Mental Health *Please provide detail*

Depression / Mania	
Anxiety	
Psychosis	
Substance Use	
Trauma	
Personality Disorder	
Family Stressors	
Formal Psychiatric Diagnosis	
Medical Issues / Medications	
Suicidal Ideation / Self-Harm	
Violence	
Legal Involvement	