Brightshores Health System

# Child/Adolescent Psychiatric Clinic Referral Form

*Please do not fax this cover sheet back with the completed referral*

## For Referring Providers

- Brightshores Child/Adolescent Psychiatry offers evidenced based assessments for ages *6 - 17.5* years
- A Physician /Nurse Practitioner referral is required
- Child/Adolescent Psychiatric clinic does *not* offer:
  - Individual Counselling
  - Assessments, treatment and/or rehabilitation for Acquired Brain injury (ABI), Traumatic Brain Injury (TBI), or concussion
  - Formal Autism Spectrum Disorder assessments (i.e. A-DOS)
  - Assessments to diagnose Intellectual or Learning Disabilities
  - Parenting capacity/custody access or forensic assessments
  - Disability assessments i.e. for the Ontario Disability Support Program (ODSP) or insurance (workplace) providers
  - Assessments for legal purposes (criminal or civil)

## For your Patient and Family

- Please ensure your patient/parent/guardian is aware the referral is being made
- A mental health clinician will review each referral
- Two attempts will be made to call the patient/family. A letter/notification will be sent to the referring provider if no contact is made
- Patients will be made aware of any waitlists when contact is made
- To assist patients/families in getting the most out of the wait time, please direct them to these online resources: https://www.gbhs.on.ca/mental-health-addiction-services/ or https://www.gbhs.on.ca/wp/wp-content/uploads/2021/04/MH-Resources.pdf or www.drtavares.ca
- Patients should provide *at least* 24 hours for any cancellation notices or rescheduling requests
- Patients who do not present for initial appointment or two follow up appointments, without appropriate notice, will have their file closed, and will require a new referral

## Psychiatric Consultation Criteria

- One time consultation is available with the understanding that the referring physician is responsible for the implementation of the recommendations
- Consultation and psychiatric follow up may be offered at time of consultation
- Requests for "2nd Opinion" consults in less than one year's time of initial consultation will be declined with few exceptions
- If your patient is seeking treatment/support for Substance Misuse, patients are encouraged to self-refer to Addiction Treatment Services to review options at 519-376-5666 or CHOICES Youth Drug & Alcohol Counseling at 519-371-5487

## How to Refer to Child/Adolescent Psychiatric Clinic

- Complete the online referral and **fax to 519-378-1447**
- Please print this page to share information and resources with your patient
- Please ensure the form is fully completed (including specific clinical consultation question) as incomplete referrals will be returned to you and delay service for your patient
- General Inquires please call 519-378-1450

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**Child and Adolescent**
**Psychiatric Clinic Referral**
**Monday to Friday Service**
**Fax: 519-378-1447**

| **Referring Physician Information** | | |
|---|---|---|
| Physicians Name: | | OHIP Billing # |
| Family Health Team or Emergency Department: | | |
| Tel: | Fax: | Email: |
| Family Physician (if different): | | |

| **Patient Information** *please note that Guardian name and contact information **must** be completed* | | |
|---|---|---|
| Last Name: | First Name: | MRN (if available): |
| Address: | | |
| Postal Code: | Tel: | Gender: |
| DOB (MM/DD/YY): | Health Card Number: | Version Code: |
| Guardian Name(s) : | | |
| Consent to email: ☐ Yes ☐ No | | |
| Guardian email: | | |
| Consent to leave voicemail with guardian: ☐ Yes ☐ No | | |

| **Other Information** | |
|---|---|
| Reason for Referral: | |
| Current Medication(s): | |

**MAJOR CONCERNS**

☐ Suicidal Behaviours: ☐ Current ☐ Past Please Specify_____
☐ Self- Harm: Type (please specify): _____
☐ Strange, Bizarre Behaviour: ☐ Hallucinations ☐ Delusions
☐ Developmental Delay
☐ FAE/FAS
☐ Socialization Problems
☐ School Problems: ☐ Academic ☐ Behavioural ☐ Truancy ☐ Other: _____
☐ ADHA: ☐ Inattentive ☐ Impulsive ☐ Hyperactive
☐ Oppositional Defiant
☐ Aggressive Behaviour: ☐ Verbal ☐ Physical ☐ Other: _____
☐ Conflict with the law? Please specify _____
☐ Sexual Acting Out: ☐ Current ☐ Past Please specify _____
☐ Mood Problems: ☐ Depression ☐ Mood Swings ☐ Elevated Mood
☐ Anxiety ☐ Obsessions ☐ Compulsions ☐ Worry ☐ Avoidant Behaviour
☐ Somatization
☐ Sleeping Problems
☐ Eating Disorder: Please explain _____
☐ Family Conflict: ☐ Separation from Parents/ Family ☐ Grief ☐ Other: _____
☐ Witnessed Traumatic Events: ☐ Physical ☐ Emotional ☐ Sexual
☐ Experienced Trauma: ☐ Physical ☐ Emotional ☐ Sexual

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**Is this child/ adolescent currently involved with any other Mental Health Agency or Psychiatrist**? If yes, please provide name(s) and contact details.

**Family History of Mental Illness** (please specify and attach additional information if needed):

**Other significant information** (please specify and attach additional information if needed):

***INTERNAL OFFICE USE ONLY***

Additional documents scanned ☐ Yes ☐ No

Total number of additional pages scanned _____

Barcode is inserted here.