Health Sciences North/ Horizon Santé Nord

PEDIATRIC PSYCHIATRY

INFORMATION FOR REFERRAL SOURCE

1) Please complete the following:

   REFERRAL FORM **-Page 2 & 3** (completed by referral source)

   PATIENT FORM **-Page 4** (completed by legal guardian/patient)

2) Please include all relevant reports, labs, tests, medication lists, consultations, etc.

3) Incomplete referrals will be returned

4) We will send a consultation note once the patient has been seen

5) Please fax completed referrals for pediatric psychiatry to: **(705) 688-7770**

INFORMATION FOR LEGAL GUARDIAN/PATIENT

1) Your child/youth's referral will be sent to the **Psychiatric Outpatient Clinic located at 680 Kirkwood Drive**

2) You will receive a call from the program to schedule an appointment

3) Please contact us at (705) 675-5900 extension 8234 if there is any change to your contact information

4) Please bring ALL of your medication bottles, including those for other medical conditions

5) Please arrive 10 minutes before your appointment time to register

IMPORTANT

1) If the patient is in crisis, please present to:
   City of Greater Sudbury- 127 Cedar Street or the Emergency Department
   All other communities- your closest Emergency Department

2) The Psychiatric Outpatient Clinic **does not accept any urgent** referrals

Referral Date: _____

PEDIATRIC PSYCHIATRY -PSYCHIATRIC OUTPATIENT CLINIC
Referral Form (17 & under)

To Be Completed By Referral Source (1 of 2)

PATIENT NAME: _____

Address: _____

City: _____

Postal Code: _____

DOB: _____ AGE:_____

Health Card#: _____VC_____

CONTACT INFO:

Tel: _____

Cell: _____

Gender: ❒ Female ❒ Male ❒ Non binary
Language: ❒ English ❒ French ❒ Other _____

Is patient agreeable to the referral? ❒ Yes ❒ No

CUSTODIAL PARENT/LEGAL GUARDIAN:

Name: _____

Relationship to patient: _____

Tel: _____

SCHOOL INFORMATION
Attending school? ❒ Yes ❒ No
Name of school: _____
Grade: _____

Is there an Individual Education Plan (IEP)?
❒ Yes ❒ No

REFERRAL SOURCE: _____

Address: _____

City: _____

Postal Code: _____

Tel: _____

Fax: _____

CHECK ONE:
❒ Family Physician ❒ Nurse Practitioner
❒ Pediatrician ❒ Other: _____
BILLING #: _____

Are you the Primary Care Provider?
❒ Yes ❒ No If no, who**:** _____

Has the patient seen a psychiatrist before?
❒ Yes ❒ No If yes, who**:** _____

Any admission to psychiatry in the past?
❒ Yes ❒ No If yes, when**:**_____

Are you requesting a specific psychiatrist?
❒ Yes ❒ No If yes, who**:** _____

Community agency involvement
Children's Aid Society ❒ Yes ❒ No ❒ Unknown
Compass ❒ Yes ❒ No ❒ Unknown
(previously Child and Family Centre)
Children's Community Network
❒ Yes ❒ No ❒ Unknown
Child Care Resources ❒ Yes ❒ No ❒ Unknown
Employee Assistance Program
❒ Yes ❒ No ❒ Unknown

Other (please specify): _____

To Be Completed By Referral Source (2 of 2)

PATIENT NAME: _____

REASON FOR REFERRAL

RELEVANT MEDICAL & TREATMENT HISTORY
ALLERGIES: ❒Yes ❒No (if yes, please specify): _____

RISK ISSUE	**CHECK**	**WHEN?**	**DETAILS**
Suicide attempt/Ideation	❒Yes ❒No		
Deliberate Self- harm	❒Yes ❒No		
Violent Behaviour	❒Yes ❒No		
Legal Involvement	❒Yes ❒No		

CURRENT MEDICATIONS LIST ATTACHED ❒Yes ❒No			
Medications	**Current**	**Dose**	**Response and Adverse Effects**
	❒Yes ❒No		
	❒Yes ❒No		
	❒Yes ❒No		

REQUIRED LAB RESULTS (these results and relevant reports must be included with the referral)			
CBC results:	**LFT** results:	**TSH** results:	**BhCG** results:

To Be Completed By Legal Guardian/Patient (over 12 yrs)/ À remplir par le (la) tuteur legal/ patient (e) (plus de 12 ans)

PATIENT NAME: NOM DU (DE LA) PATIENT(E) : _____

Address/ Adresse: _____ City/ Ville: _____

Postal Code/ Code postal: _____ Email/ Courriel: _____

Tel/ Tél: _____ Cell: _____

Can we leave confidential message? Pouvons-nous laisser un message confidentiel? ❒ Yes/Oui ❒ No/Non

Preferred name/name change, if different from above:_____
Nom préféré, changement de nom (si différent de celui ci-dessus)

PLEASE COMPLETE TO THE BEST OF YOUR ABILITY/ VEUILLEZ REMPLIR CETTE SECTION DU MIEUX QUE VOUS LE POUVEZ :

1) Do you think you need to see a psychiatrist? / À votre avis, avez-vous besoin de consulter un psychiatre?
❒ Yes/ Oui ❒ No / Non -If yes, why? / Si oui, pourquoi? _____

2) Are you being pressured to see a psychiatrist? / Vous pousse-t-on à consulter un psychiatre?
❒ Yes / Oui ❒ No/ Non - If yes, why? / Si oui, pourquoi? _____

3) Do you have a previous diagnosis(s)? / Avez-vous reçu un diagnostic dans le passé?
❒ Yes / Oui ❒ No/ Non - If yes, what? / Si oui, quoi? _____

4) Family history of mental illness or addictions? / Y a-t-il de la maladie mentale ou de la toxicomanie dans votre famille?
❒ Yes / Oui ❒ No/ Non - If yes, what? / Si oui, quoi? _____

5) Have you ever been seen by a psychiatrist? / Avez-vous déjà consulté un psychiatre?
❒ Yes / Oui ❒ No/ Non - If yes, why? / Si oui, pourquoi? _____

6) Mental Health or Addiction Programs in the past? / Avez-vous déjà participé à un programme de santé mentale ou de toxicomanie?
❒ Yes / Oui ❒ No/ Non - If yes, which program(s)? / Si oui, quel(s) programme(s)?_____

7) Do you have any issues with substances (drugs)? / Avez-vous des problèmes de consommation de substances (drogues)?
❒ Yes / Oui ❒ No/ Non

8) Do you have any issues with alcohol? / Avez-vous des problèmes de consommation d'alcool?
❒ Yes / Oui ❒ No/ Non