



**PEDIATRIC PSYCHIATRY**

**INFORMATION FOR REFERRAL SOURCE**

- 1) Please complete the following:  
**REFERRAL FORM - Page 2 & 3** (completed by referral source)
- 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**

**INFORM YOUR PATIENT OR LEGAL GUARDIAN/PATIENT  
OF THE FOLLOWING**

- 1) The referral will be sent to the **Psychiatric Outpatient Clinic (POC) at 680 Kirkwood Drive**
- 2) They will receive a call from the program to schedule an appointment
- 3) Contact the clinic directly at (705) 675-5900 extension 8234 if there is any change to their contact information
- 4) Bring a list of their medications, including those for other medical conditions and over the counter medications
- 5) Arrive 10 minutes before their appointment time to register

**IMPORTANT**

- 1) The Psychiatric Outpatient Clinic **does not accept any urgent** referrals
- 2) If the patient is in crisis, please present to:
  - The Crisis Intervention Program 24/7 at 705-675-4760 for support (City of Greater Sudbury)
  - The general crisis line at 988 for all other communities
- 3) The POC clinic is no longer accepting re-referrals within 1 year for new client consults that did not attend.



Referral Date: \_\_\_\_\_

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

To Be Completed By Referral Source (1 of 2)

<p><b>PATIENT NAME: (Last)</b> _____ <b>(First)</b> _____</p> <p><b>Address:</b> _____ <b>City:</b> _____ <b>Postal Code:</b> _____</p> <p><b>DOB:</b> _____ <b>AGE:</b> _____</p> <p><b>Health Card#:</b> _____</p> <p><b>Gender:</b></p> <p><input type="checkbox"/> Choose not to disclose</p> <p><input type="checkbox"/> Male</p> <p><input type="checkbox"/> Female</p> <p><input type="checkbox"/> Non-Binary/Gender Diverse</p> <p><input type="checkbox"/> Transgender Male/Female</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Transgender Female/ Male</p> <p><b>Language:</b> <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other _____</p> <p><b>Is patient agreeable to the referral?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b><u>CONTACT INFO:</u></b></p> <p><b>Tel:</b> _____</p> <p><b>Cell:</b> _____</p> <p><b>Email:</b> _____</p> <p><b><u>CUSTODIAL PARENT/LEGAL GUARDIAN:</u></b></p> <p><b>Name:</b> _____</p> <p><b>Relationship to patient:</b> _____</p> <p><b>Tel:</b> _____</p> <p><b><u>SCHOOL INFORMATION</u></b></p> <p><b>Attending school?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Name of school:</b> _____</p> <p><b>Grade:</b> _____</p> <p><b>Is there an Individual Education Plan (IEP)?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b>REFERRAL SOURCE:</b></p> <p>_____</p> <p><b>Address:</b> _____</p> <p><b>City:</b> _____</p> <p><b>Postal Code:</b> _____</p> <p><b>Tel:</b> _____</p> <p><b>Fax:</b> _____</p> <p><b>Goal of Referral:</b> <input type="checkbox"/> Diagnosis</p> <p><input type="checkbox"/> Second Opinion</p> <p><input type="checkbox"/> Treatment Recommendations</p> <p><b><u>CHECK ONE:</u></b></p> <p><input type="checkbox"/> Family Physician <input type="checkbox"/> Nurse Practitioner</p> <p><input type="checkbox"/> Other: _____ <b>BILLING #:</b> _____</p> <p><b>PROFESSIONAL ID:</b> _____</p> <p><b>Has the patient seen a psychiatrist before?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, who: _____</p> <p><b>Any admission to psychiatry in the past?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, when: _____</p> <p><b>Are you requesting a specific psychiatrist?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, who: _____</p> <p><b>Community agency involvement</b></p> <p>Children's Aid Society:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Compass:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Children's Community Network: (previously Child and Family Centre)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Child Care Resources:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Employee Assistance Program:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Other (please specify):</p>
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**Health Sciences North/ Horizon Santé Nord**



To Be Completed By Referral Source (2 of 2)

**PATIENT NAME:** \_\_\_\_\_

<b>NAME OF SUSPECTED DIAGNOSIS/PROBLEM TRIGGERING REFFERAL</b>
*Please attach <b>all relevant</b> laboratory and diagnostic investigations from the last <b>6 months</b> .
<b>MEDICAL HISTORY AND ALLERGIES</b>
<b>ALLERGIES:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, please specify):
<b>SOCIAL HISTORY</b>
<b>FAMILY HISTORY</b>
<b>TREATMENTS</b>

RISK ISSUE	CHECK	WHEN?	DETAILS
Suicide attempt/Ideation	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Past History <input type="checkbox"/> Ongoing	
Deliberate Self- harm	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Past History <input type="checkbox"/> Ongoing	
Violent Behaviour	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Past History <input type="checkbox"/> Ongoing	
Legal Involvement	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Past History <input type="checkbox"/> Ongoing	

<b>CURRENT MEDICATIONS LIST ATTACHED</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
Medications	Current	Dose	Response and Adverse Effects
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		

**Personal Health information that is medically relevant has not been disclosed at the request of the patient.**