Mackenzie Health

Mackenzie Richmond Hill Hospital
10 Trench Street
Richmond Hill, Ontario
L4C 4Z3

Patient Name: ____________________

Place Patient Barcode Label Here

Shaw Clinic Child and Family Services
Mental Health Program
(Providing Mental Health Services for Ages 6-18 years)
Referral Form for Psychiatric Services

*** Patient must consent to this referral if they have capacity to do so.**

Telephone: 905-883-2137 or 905-832-4554 ext. 2137 Fax: 905-883-2144

The child and family clinic is NOT able to accept referrals for assessments/treatments where concerns are related principally to:

- Legal issues
- If parents are actively in court regarding custody
- Anger management
- Behavioural disorders
- Eating disorders
- Primary substance abuse

Referring doctor: ____________________

Address: ____________________

Phone Number: ____________ Fax Number: ____________ Billing Number: ____________

____________________ Physician Signature

____________________ Date (dd/mm/yyyy)

Patient Information:

Date of Referral: ____________________
dd/mm/yyyy

Patient Name: ____________________ Last Name First Name

Date of Birth: ____________ dd/mm/yyyy

Address: ____________________ OHIP#: ____________

Legal Guardian Name(s): ____________________

Email Address of primary contact for referral (required) ____________________

(Please ensure your patient is aware to regularly check their "Junk" box as often email servers are filtering the hospital emails to "Junk" due to their settings)

Please include all numbers where patient/legal guardian can be contacted:

Home Telephone: ____________________

Legal Guardian's Cell Phone: ____________________
(If patient is incapable or agrees to provide)

Patient's Cell phone: ____________________

*Patient will not be contacted for this referral unless you acknowlege that a voicemail can be left at the above numbers by initialing here: ________
Initials

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Custodial status of guardian(s):

☐ Not Applicable ☐ Joint Custody ☐ One Parent Has Sole Custody, Name: ______________________

☐ No Formal Custody ☐ Other: ______________________

Reason for Referral: (please provide details)

____

____

____

☐ Requires assessment to determine if the patient has an ADHD Diagnosis or not

☐ Has ADHD Diagnosis but requires an ADHD medication consult

Is there a current mental health diagnosis? ☐ Yes ☐ No

____

____

Please check any of the following mental health issues of concern to you:

☐ Significant anxiety or fears
☐ Decreased academic performance
☐ Depressed mood
☐ Suicidal thoughts; recurrent thoughts about death
☐ Impaired school attendance

☐ Decreased interest in or avoidance of activities
☐ Sleep changes
☐ Change in appetite
☐ Somatic complaints
☐ Social withdrawal
☐ Decreased self care

☐ Hallucinations (hear, see, feel, taste, smell things)
☐ Delusions (bizarre thoughts)
☐ Flight of ideas/racing thoughts
☐ Suspected alcohol/drug abuse
☐ Developmental disability

RISKS:			**Please explain:**
Threat of self	☐ No	☐ Yes	When:
Threat to others	☐ No	☐ Yes	When:
Suicidal Ideation / Plan / Intent	☐ No	☐ Yes	When / Describe:
Violent behaviour	☐ No	☐ Yes	When:

Please list any current medications (Medication/Dose/Duration)

____

____

____

Allergies: ____

Other relevant health problems: ____

____

Please forward recent investigations: (e.g., Blood work, EKG, Psychological Reports)
Completed By:

Name: ______________________ Signature: ______________________ Date: ______________________
dd/mm/yyyy