Mackenzie Health

Mackenzie Richmond Hill Hospital
10 Trench Street, Richmond Hill ON L4C 4Z3
905-883-1212

Cortellucci Vaughan Hospital
3200 Major Mackenzie Drive West, Vaughan ON L6A 4Z3
905-417-2000

Patient Name:

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 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: _____ Date of Birth: _____
Last Name First Name 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 agree to provide)

Patient's Cell Phone: _____

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

Patient Name:

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Custodial status of guardian(s):

☐ No Applicable ☐ Joint Custody ☐ One Parent Has Sole Custody, Name: _____
☐ No Formal Custody ☐ Other: _____

Reason for Referral: (please provide details)

_____

_____

_____

☐ 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 selfcare
☐ 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 to self	☐ No	☐ Yes	When:
Threat to others	☐ No	☐ Yes	When:
Suicidal Ideation / Plan / Intent	☐ No	☐ Yes	When/Described:
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