McMaster Children's Hospital

CHILD AND YOUTH MENTAL HEALTH PROGRAM

Psychiatry Consultation Referral Form

*** PLEASE DIRECT ANY INQUIRIES TO 905-521-2100 ext. 74382 ***

This form is to be used for ONE-TIME psychiatry consultation for children and youth from birth to their 18th birthday**.**

This form is NOT to be used for urgent psychiatric consultation. If you are concerned about acute safety issues for your patient (e.g., suicidal ideation), please contact your local crisis service or direct your patient to the nearest Emergency Room.

To request psychiatric consultation services, please fill out ALL SECTIONS of this form and fax to **905-521-7938 to initiate your referral.** Incomplete forms will be returned.

This form is NOT to be used for ongoing services. If such services are required, including ongoing psychiatric involvement, please have the patient/family call **Contact Hamilton** (905-570-8888).

REASON FOR REFERRAL & PATIENT INFORMATION

Reason for referral (select at least one):

○ Diagnostic clarification ○ 2nd Opinion ○ Medication Consultation

Last Name: _____ First Name: _____ Middle Name: _____

DOB: _____ Age: _____ HIN#_____ Expiry Date: _____ Gender: _____

Street:_____ City: _____ Postal Code: _____

Cell Phone#: _____Home Phone #:_____ Email: _____

Contact Person:_____ Relationship: _____ Phone #:_____

PARENT/GUARDIAN INFORMATION

Name: _____ Relationship: _____Phone #:_____ Legal Guardian: Y / N

Name: _____ Relationship: _____ Phone #: _____ Legal Guardian: Y / N

○ Interpreter required? If yes, language _____

REFERRING PHYSICIAN/NP (mandatory for accessing service)

Last Name: _____ First Name: _____ Phone #:_____

Specialty (e.g. GP, Pediatrician, Psychiatrist) _____

Address:_____ Fax #:_____ Billing #:_____

Family Physician (if different from referring physician): _____ Is the GP part of a FHT? Y / N

SAFETY & CURRENT CONCERNS

Any CURRENT safety concerns? ○ **No** ○ **Yes – please specify below:**

○ Self-Harm
○ Aggression
○ Suicidal ideation
○ Recent suicide attempt
○ Homicidal ideation
○ Other: _____

Please check off all the CURRENT concerns:

- ○ Anxiety
- ○ Inattention
- ○ Substance Use
- ○ Delusions
- ○ Depression
- ○ History of trauma
- ○ Other: _____
- ○ Hyperactivity
- ○ School Difficulties
- ○ Developmental Delay
- ○ Anger
- ○ Oppositional Behaviour
- ○ Hallucinations
- ○ Family Relationship Difficulties
- ○ Obsessions/Compulsions
- ○ Legal Involvement

SERVICES CURRENTLY INVOLVED WITH CHILD/FAMILY AND OTHER CARE PROVIDERS

Has the patient accessed other services? ○ No ○ Yes – please specify below:

- ○ CONTACT Agency: _____
- ○ Community Mental Health Agency: _____
- ○ Psychiatrist: _____
- ○ Pediatrician: _____
- ○ Psychologist: _____
- ○ Youth Justice
- ○ Developmental Services
- ○ Speech and Language Pathology
- ○ Family Health Team MH Clinician
- ○ Child Welfare
- ○ School/Special Education
- ○ Other: _____

Relevant Medical History

Please provide details on Medication History:

Medication	Dose/Frequency	Date started	Date Stopped	Comments

Please provide details on the level of severity of the mental health concerns and the effect on the patient's functioning:

Does the patient/guardian being referred consent to the CYMHP forwarding this information to Contact Hamilton OR the Youth Wellness Centre (for youth age 17) to meet the mental health concerns indicated on this form (<u>one box must be checked</u>)? ○ YES ○ NO

Please note that this is not a transfer of care. In referring this patient, I understand that this is a consultation-only service and ongoing care will be provided by the family doctor or other physicians connected with this patient's care.

Physician/NP Signature: _____ Date:_____

When submitting this referral, please include available supporting documents and reports (e.g. previous mental health and psychiatric assessments, psychological testing reports, relevant medical reports etc.)

Please fax this completed form and attachments to 905-521-7938 to initiate your referral.