

\*\*\* PLEASE DIRECT ANY INQUIRIES TO 905-521-2100 ext. 74831 \*\*\*

**This form is to be used for referral to the Day Treatment program.**

**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 Day Treatment Service, please fill out ALL SECTIONS of this form and fax to **905-521-7978** to initiate your referral. Incomplete forms will be returned.

**This form is NOT to be used for psychiatric consultation or other program services.** The Day Treatment Service provides adjunct treatment to community-based mental health interventions. Youth go through a screening process to know that they are appropriate for a particular cohort. Goals include learning and practicing coping skills and preparing and planning for educational activities. Youth may have recently been inpatients. Youth are referred by community mental health professionals and agencies in LHIN 4.

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ HIN# \_\_\_\_\_ Expiry Date: \_\_\_\_\_ Sex Assigned at Birth: \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Gender Identity: \_\_\_\_\_

Cell Phone#: \_\_\_\_\_ Home Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Patient School Board: \_\_\_\_\_ Patient School: \_\_\_\_\_ Grade: \_\_\_\_\_

**PARENT/GUARDIAN INFORMATION**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_ Legal Guardian: Y / N

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_ Legal Guardian: Y / N

Interpreter required? If yes, language \_\_\_\_\_

**REFERRING PROFESSIONAL**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Profession (e.g. GP, Pediatrician, Psychologist) \_\_\_\_\_ Agency: \_\_\_\_\_

Address: \_\_\_\_\_ Fax #: \_\_\_\_\_

Primary Care Provider (if different from referring professional): \_\_\_\_\_ PCP Phone #: \_\_\_\_\_

**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

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

**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: \_\_\_\_\_

**Allergies:**

**Additional Health Concerns:**

**Please provide details on Medication History:**

Medication	Dose/Frequency	Prescribed by

**Please note that this is not a transfer of care, but a request for additional service. Please forward the most recent comprehensive mental health assessment.**

**Professional's 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 905-521-7978 to initiate your referral.**

For receiving Date Received: (yyyy/mm/dd) \_\_\_\_\_

Disposition:  Accepted  Not Accepted

Service only: Assigned to: \_\_\_\_\_

Date (yyyy/mm/dd) \_\_\_\_\_

Team Leader Printed Name \_\_\_\_\_

Signature and Designation \_\_\_\_\_