McMaster Children's Hospital

CHILD AND YOUTH MENTAL HEALTH PROGRAM (CYMHP)

Pediatric Mental Health Consult Service – Referral Form

Form 712683 (2025-05)

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

This referral is for a BRIEF mental health consultation for children and youth from age 4 to their 18th birthday.

Please fill out ALL SECTIONS of this form and **fax completed form and attachments to 905-521-7938** to initiate your referral. Incomplete forms will be returned

This service is NOT:

- **Urgent 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.
- **Multidisciplinary Care** – If such services (e.g. Psychotherapy) are required, please have the patient/family call their local Mental Health Access Agency (e.g., Lynwood Access and System Navigation (ASN), Pathstone, Woodview, REACH).
- **Assessment for Neurodevelopmental Disorders** - For access to Developmental, FAS, ASD, and/or Complex Needs services, please have the patient/family contact their local Contact agency.
- **Transfer of Care** – This is a consultation-only service with the expectation that ongoing care will be provided by the family doctor or other physicians/nurse practitioners connected with this patient's care. Continuing/ongoing care may be provided as indicated by the Psychiatrist following the consultation.

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REASON FOR REFERRAL & PATIENT INFORMATION

Reason(s) for referral (only the following options are eligible for this service):

☐ Diagnostic clarification ☐ Medication Consultation ☐ 2nd Opinion ☐ Indirect telephone consult

Clearly indicate the specific question you want answered.

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

Preferred / Used name: (if different than on health card)

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

DOB: (yyyy/mm/dd) _____ Age: _____ Gender: _____

HIN #_____ Version: _____ Expiry Date: (yyyy/mm/dd) _____

Street:_____ City: _____ Postal Code: _____

Cell Phone #: _____ Home Phone #:_____

Email (mandatory): _____ (if not available, must include email of parent / guardian

PARENT / GUARDIAN INFORMATION

Name: _____ Relationship: _____ Phone #:_____

Email: _____ DOB:_____ Legal Guardian: ☐ Yes ☐ No

Name: _____ Relationship: _____ Phone #:_____

Email: _____ DOB:_____ Legal Guardian: ☐ Yes ☐ No

Interpreter required? If yes, language _____

REFERRING PHYSICIAN / NP (mandatory for accessing service)

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

Specialty (e.g. Family Physician, Pediatrician, Psychiatrist) _____

Address:_____ Fax #: _____ Billing #:_____

PCP (if different from referring physician):_____

Is the Primary Care Provider (PCP) part of a Hamilton Family Health Team (FHT)? ☐ Yes ☐ No

I understand that this is a consultation-only service and ongoing care will be provided by the Referring Physician / Primary Care Physician / NP connected with this patient's care.

Referral Date: (yyyy/mm/dd) _____ Physician / NP Signature: _____

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Patient: _____ DOB: _____ Referral Date: _____

CURRENT SAFETY CONCERNS ☐ None

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

Please check off all the CURRENT concerns:

☐ Anxiety ☐ Hyperactivity ☐ Oppositional Behaviour
☐ Inattention ☐ School Difficulties ☐ Hallucinations
☐ Substance Use ☐ Developmental Delay ☐ Family Relationship Difficulties
☐ Delusions ☐ Anger ☐ Obsessions/Compulsions
☐ Depression ☐ Eating Concerns ☐ Legal Involvement
☐ Trauma ☐ Social Difficulties Other: _____

Please describe severity of symptoms:

SERVICES CURRENTLY INVOLVED WITH CHILD/FAMILY AND OTHER CARE PROVIDERS

☐ Mental Health Access Agency: _____ ☐ Developmental Services: _____
☐ Mental Health Services: _____ ☐ Child Welfare: _____
☐ Psychiatrist: _____ ☐ School/Special Education: _____
☐ Pediatrician: _____ ☐ Youth Justice: _____
☐ Psychologist: _____ ☐ Other: _____

Provide or Attach Relevant Medical History & Medication History Including Allergies

Medication	**Dose/Frequency**	**Date started** (yyyy/mm/dd)	**Date Stopped** (yyyy/mm/dd)	**Comments**

Comments:

The following 4 questions must be answered for the referral to be considered.

Does the youth consent to this referral? ☐ Yes ☐ No

Does the youth / caregiver(s) consent to CYMHP forwarding this information to the patient's **Local Mental Health or Developmental Centralized Intake Agency** (e.g. Lynwood ASN, Pathstone, Woodview,REACH, CONNECT (for youth 18+), Contact Hamilton) to meet the mental health concerns indicated on this form? ☐ Yes ☐ No

Does the youth consent to their caregiver(s) providing additional information regarding this referral? ☐ Yes ☐ No

All available supporting documents and reports (e.g. previous mental health and psychiatric assessments, psychological testing reports, relevant medical reports, etc.) are attached. ☐ Yes ☐ No