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.**

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

Please select the reason for referral:

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

Please check off any CURRENT safety concerns:

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

Please check off all the CURRENT concerns:

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

- ○ Other: ____

SERVICES CURRENTLY INVOLVED WITH CHILD/FAMILY AND OTHER CARE PROVIDERS

Please Indicate if the patient has accessed:

- ○ 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 being referred consent to the CYMHP forwarding this information to the local Contact agency OR the Youth Wellness Centre (for youth age 17) to meet the mental health concerns indicated on this form (one box must be checked)?

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.

Signed: ____ **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.