McMaster Children's Hospital

CHILD AND YOUTH MENTAL HEALTH PROGRAM

Day Treatment Service

*** PLEASE DIRECT ANY INQUIRIES TO 905-521-2100 ext. 72831 ***

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 905-577-8438 "attention Day Treatment" 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 and functional 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 ☐ 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: _____

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

Please list SMART goals focused on the client's function related to school, work, peers, family, recreational activities:

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

Medication	Dose/Frequency	Prescribed by

Please note that this is not a transfer of care, but a request for additional service.

Professional's Signature: _____ Date: _____

When submitting this referral, please include the most recent comprehensive mental health assessment

Please fax this completed form to 905-577-8438 "attention Day Treatment" to initiate your referral.