McMaster Children's Hospital

Pediatric Adolescent Medicine Program Referral Form

Physician/Nurse Practitioner Referral Only

Referral Date:

PHYSICIAN INFORMATION

Referring MD/NP: _____

Specialty:_____

Phone: _____ Fax: _____

Billing Number: _____

Primary Care Practitioner: _____

Phone: _____ Fax: _____

PATIENT INFORMATION

Last Name: _____ Legal First Name: _____

DOB: _____ Age: _____ Sex Assigned at Birth: _____

Affirmed/Chosen Name: _____ Pronouns Used: _____

Current Gender Identity: _____

Address: _____City: _____ Postal Code: _____

Health Card Number: _____ Version Code: _____

CAREGIVER INFORMATION

Parent/Caregiver Name: _____

Relationship to Child: _____

Home Phone: _____ Other Phone: _____

Email: _____

Is an interpreter required? ❑Yes ❑No If yes, which language? _____

Is the patient/family aware of this referral? ❑Yes ❑No

Is this referral confidential? ❑Yes ❑No *If yes, please contact Clinical Specialist at ext 73049*

PERSON TO CONTACT

Is the parents/caregivers aware of this referral? ❑Yes ❑No

Are parents/caregivers supportive of this referral? ❑Yes ❑No

If yes, we will use the contact number listed under "Caregiver Information".

If no, please list below the name and number of the person we are to contact regarding appointment details.

Name: _____ Number: _____

Relationship to patient: _____

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REASON FOR REFERRAL – REQUIRED INFORMATION

Reason for Referral:

☐ Conversion Disorder/Functional Neurological Disorder
☐ Treatment adherence in the context of a chronic health condition
☐ Complex comorbid chronic illness and mental health concerns
☐ Complex sexual health concerns in patients with chronic health conditions
☐ Somatic Symptoms
☐ Substance use and complex chronic medical conditions

Anticipated Goals or Questions for Referral:

_____

_____

_____

_____

History

Is there a history of ☐ Self Harm ☐ Suicidality If so, please provide details:

_____

_____

_____

_____

_____

Team members involved OR previously involved:

❑ Psychiatry (name & contact #) _____
❑ Consult attached

❑ Social Work (name & contact #) _____
❑ Consult attached

❑ Private practitioner (name and contact #) _____
❑ Consult attached

❑ Other (service, name, and contact #) _____

CAS Involvement:

- ❑ None
- ❑ Past
- ❑ Current (name and contact #) _____

Is the patient currently receiving mental health services? ❑Yes ❑No Where: _____

Have you referred to a general mental health service? ❑Yes ❑No Where: _____

Any recent admissions or ER visits? ❑Yes ❑No If yes, please attach the details of those visits.

Attach copies of initial medical assessment including all blood work done.

Attach copies of all mental health/family assessments.

Medications:

- ❑ No medication has been prescribed
- ❑ Patient has declined use of medication
- ❑ Patient has been and is currently taking the following medications (please include doses, duration, and whether prescription is past or current)

Medication	Dose	Duration	Past or Current
			❑ **Past** ❑ **Current**
			❑ **Past** ❑ **Current**
			❑ **Past** ❑ **Current**

If the primary concern is around suicidality, the patient should be assessed by the local mental health/crisis team

We recommend regular monitoring by referring clinicians of physical and mental health status. If there are deteriorations in clinical status, please contact the physician on call for Adolescent Medicine.

You will receive a letter indicating the status of your patient's referral. Your patient will be contacted directly with their appointment.

Referring Provider Signature: _____

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Please fax the completed referral form to 905-521-2330.
Note: Referral must be complete to be considered. Incomplete referrals will not be processed.

A digital version of this referral form is available on the McMaster Children's Hospital Website.