

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  NoIs 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  NoAre 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: \_\_\_\_\_

**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:**

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**History**

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

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**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   |
|------------|------|----------|---|
|            |      |          | <input type="checkbox"/> Past<br><input type="checkbox"/> Current |
|            |      |          | <input type="checkbox"/> Past<br><input type="checkbox"/> Current |
|            |      |          | <input type="checkbox"/> Past<br><input type="checkbox"/> 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:** \_\_\_\_\_

# Pediatric Adolescent Medicine Program Referral Form

*Physician/Nurse Practitioner Referral Only*

**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.*