



Addressograph /
Patient ID Label (Bar Code)

REFERRAL INFORMATION CHILD, YOUTH AND FAMILY PROGRAM

Client/Patient Name: _____ Health Record #: _____
(Last Name, First Name)

Please Note the following information:

- **WE DO NOT OFFER EMERGENCY OR CRISIS SERVICE**
- **Please print clearly and ensure contact information is correct. Complete all forms.**
- **We will contact the family to set up the assessment appointment**
- ***Include any relevant medical reports, psychological reports, and copies of previous psychiatric consultations or discharge summaries, along with Disclosure of Health Information Form. Failure to do so could result in a delay of the referral process. The form is available for download from***

http://www.health.gov.on.ca/english/providers/legislation/priv_legislation/consent/consent_disclose_form.pdf

Date of Referral: ____/____/____ (dd/mm/yyyy)

REFERRAL SOURCE INFORMATION:

Physician Agency Legal Other _____

Name: _____ Billing# (if applicable): _____

Address: _____

Telephone: _____ Fax: _____

It is helpful for child/youth to be aware of the referral. Is your client aware of this referral?
(check one) Yes No If no, please explain: _____

CHILD/YOUTH INFORMATION:

Name: _____ OHIP Registration # _____

Date of Birth (dd/mm/yyyy): _____ Male Female



* D 0 2 6 8 B *

Addressograph /
Patient ID Label (Bar Code)

**REFERRAL INFORMATION
CHILD, YOUTH AND FAMILY PROGRAM**

Client/Patient Name: _____ Health Record #: _____
(Last Name, First Name)

GUARDIAN INFORMATION:

1. Guardian Name: _____ Relationship to Client: _____

Address: _____

Home Telephone: _____ Cell: _____

E-mail address: _____

2. Guardian Name: _____ Relationship to Client: _____

Address: _____

Home Telephone: _____ Cell: _____

E-mail address: _____

Custody Status: Client Lives Independently Sole custody/ Name: _____
 Joint custody Other (CAS, relative) _____

If joint custody, are all guardians aware of the referral and approve/agree with this referral? yes no

Is there Child Welfare Involvement (CAS, CCAS, JFCS, NCFST) none past current

Interpretation Services needed? (e.g., sign language/other language)? No Yes:

Please specify language: _____

Are there barriers to communication with the client?

No Yes Please specify: _____

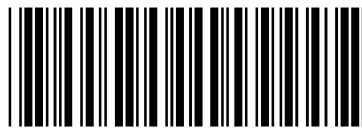
SCHOOL INFORMATION (IF APPLICABLE):

Name of **Child's/Youth's** School/College/University/Other: _____

Grade/Year: _____ School Board: _____

Type of school placement:

regular not enrolled special ed. (specify): _____



* D 0 2 6 8 B *

Addressograph / Patient ID Label (Bar Code)

REFERRAL INFORMATION CHILD, YOUTH AND FAMILY PROGRAM

Client/Patient Name: _____ Health Record #: _____
(Last Name, First Name)

CHILD/YOUTH EMPLOYMENT INFORMATION (IF APPLICABLE):

Last year of schooling (grade or postsecondary year): _____

enrolled, working not enrolled, not working school completed, working

school completed, not working Nature of Employment _____

ACADEMIC HISTORY – IF APPLICABLE

(Space on last page to provide additional information)

Academic/Learning History	Yes	No	Unsure	If yes or unsure, please provide information
Currently performing or functioning below grade level?				<input type="checkbox"/> One year below grade level <input type="checkbox"/> More than one year below grade level
Has psychological testing for academic/learning problems been given?				Please list specifics (if known):

CURRENT CONCERNS and PAST HISTORY

(Space on last page to provide additional information including family history)

Concerns	Check <u>all</u> that currently apply and indicate with an "X" <u>PRIMARY Concerns</u>	Please check off areas that client has a <u>PAST History</u> of	Check off current specific signs and symptoms that apply	How long has the client had these symptoms?
Medication Consultation				
Behavioural Concerns			<input type="checkbox"/> Verbally aggressive <input type="checkbox"/> Lying <input type="checkbox"/> Physically aggressive <input type="checkbox"/> Disruptive behaviour <input type="checkbox"/> Argumentative <input type="checkbox"/> Stealing <input type="checkbox"/> Rule breaking <input type="checkbox"/> Quick tempered	



* D 0 2 6 8 B *

Addressograph /
Patient ID Label (Bar Code)

REFERRAL INFORMATION CHILD, YOUTH AND FAMILY PROGRAM

Client/Patient Name: _____ Health Record #: _____
(Last Name, First Name)

Social Concerns			<input type="checkbox"/> Unable to make friends <input type="checkbox"/> Unable to sustain friendships <input type="checkbox"/> Unable to manage group situations <input type="checkbox"/> Misses social cues	
Fire Setting			<input type="checkbox"/> Past <input type="checkbox"/> Present	
Attention / concentration Concerns			<input type="checkbox"/> Unable to focus <input type="checkbox"/> Disruptive <input type="checkbox"/> Restless <input type="checkbox"/> Impulsive <input type="checkbox"/> Easily distracted <input type="checkbox"/> Difficulty during unstructured times	
Anxiety: Select <u>Type</u> :			<input type="checkbox"/> Phobias <input type="checkbox"/> Nightmares <input type="checkbox"/> Obsessive compulsive disorder <input type="checkbox"/> Somatic complaints <input type="checkbox"/> Fearful <input type="checkbox"/> Separation issues <input type="checkbox"/> Panic attacks <input type="checkbox"/> Refusal to attend school <input type="checkbox"/> Post-traumatic stress disorder <input type="checkbox"/> Withdrawn <input type="checkbox"/> Social <input type="checkbox"/> Generalized	
Depression			<input type="checkbox"/> Sadness <input type="checkbox"/> Sleep disruption <input type="checkbox"/> Self harm <input type="checkbox"/> Suicidal thinking/Ideation <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Lack of interest/motivation <input type="checkbox"/> Quick mood changes	
Autism, Asperger Syndrome, Pervasive Developmental Delay			<input type="checkbox"/> Rigid thinking <input type="checkbox"/> Detail oriented <input type="checkbox"/> Overly concerned with rules and fairness <input type="checkbox"/> Obsessive thoughts <input type="checkbox"/> Unable to initiate/engage in play <input type="checkbox"/> Avoids eye contact	



* D 0 2 6 8 B *

Addressograph /
Patient ID Label (Bar Code)

**REFERRAL INFORMATION
CHILD, YOUTH AND FAMILY PROGRAM**

Client/Patient Name: _____ Health Record #: _____
(Last Name, First Name)

Bipolar Mood Disorder			<input type="checkbox"/> Racing thoughts <input type="checkbox"/> Depression <input type="checkbox"/> Mania <input type="checkbox"/> Delusions <input type="checkbox"/> Mixed Episode <input type="checkbox"/> Hallucinations													
Psychotic Disorder			<input type="checkbox"/> Hallucinations <input type="checkbox"/> Hearing voices <input type="checkbox"/> Bizarre ideas <input type="checkbox"/> Seeing things <input type="checkbox"/> Delusions													
Gender identity issues																
Sexualized behaviour																
Substance(s) Used (including alcohol, nicotine, illicit, prescribed and over the counter drugs)			<i>*Is the individual expressing interest in addressing his/her current substance use?</i> (CHECK ONE) <input type="checkbox"/> No <input type="checkbox"/> Yes Substance Amount Frequency <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </table>													
Gambling			<input type="checkbox"/> Yes <input type="checkbox"/> no													

Is there a history of any of the following?	Yes	No	Unsure	If yes or unsure, please provide detailed information on the last page
Developmental handicap				
Head injury with loss of consciousness				
Legal involvement				



* D 0 2 6 8 B *

Addressograph /
Patient ID Label (Bar Code)

**REFERRAL INFORMATION
CHILD, YOUTH AND FAMILY PROGRAM**

Client/Patient Name: _____ Health Record #: _____
(Last Name, First Name)

Violent behaviour				
Suicide attempts				
Self-harming behaviour				
Personality Disorder				

REASON FOR REQUESTING THE CONSULTATION: (What is your question?)

**PAST AND PRESENT MEDICATIONS (Psychotropic and non-psychotropic)
Additional space on last page.**

Medication	Dose/ Frequency	Comments
		<input type="checkbox"/> Past <input type="checkbox"/> Present
		<input type="checkbox"/> Past <input type="checkbox"/> Present
		<input type="checkbox"/> Past <input type="checkbox"/> Present

LIST AGENCIES, THERAPIES OR HOSPITALS APPLIED TO OR SEEN IN THE PAST 2 YEARS (including CAMH): Please note that a Consent to Disclose Personal Health Information form needs to be completed (see first page for link).

NAME	WHEN/DURATION	OUTCOME/COMMENTS



* D 0 2 6 8 B *

Addressograph /
Patient ID Label (Bar Code)

**REFERRAL INFORMATION
CHILD, YOUTH AND FAMILY PROGRAM**

Client/Patient Name: _____ Health Record #: _____
(Last Name, First Name)

ADDITIONAL SPACE FOR MORE INFORMATION: FAMILY HISTORY, CLIENT STRENGTHS, CURRENT AND/OR PAST MEDICATIONS (including side effects), MEDICAL HISTORY, OTHER COMMENTS:

[Empty rectangular box for additional information]

**Please fax referral and all forms to the
Child, Youth and Family Intake office at 416-979-4272. If you require further
information, please contact Intake at 416-535-8501 x 4366**