WRHN
Waterloo Regional Health Network

MENTAL HEALTH AND ADDICTIONS PROGRAM
Fax Referral to: 519-749-4261

Request for Child and Adolescent

Services are provided to individual's 6 to 17 years who reside in the Waterloo Regional Health Network catchment area (Please note Cambridge/ North Dumfries has its own catchment area).

Patient agreeable to this referral: No ( ) Yes( )
Patient's Name:_____
Gender: Male ( ) Female ( ) Identity as other ( )

Address:_____
City:_____Postal Code:_____

DOB: dd____mm____yy____

OHIP Number:_____VC_____
Expiry Date: _____

Parent/Guardian Information (required):
Use Box 2 to provide information of second parent when residence differs and there is joint /shared custody.

Box 1	Box 2
Verbal consent obtained from parent: No ( ) Yes ( ) If no, please explain:_____ _____ Parent/guardian information: same as child □ Name(s)_____ Address_____ City:_____Postal Code:_____ Phone: Home_____Cell : _____ Confidential message can be left at home: No ( ) Yes ( )	Verbal consent obtained from parent: No ( ) Yes ( ) If no, please explain:_____ _____ Parent/guardian information: same as child □ Name_____ Address_____ City:_____Postal Code:_____ Phone: Home_____Cell : _____ Confidential message can be left at home: No ( ) Yes ( )

Physician Information:

Referring Physician:_____Billing #_____
Direct Phone (back line):_____Fax:_____
Physician Signature:_____Date of Referral:_____
Date Patient was Last Seen:_____

Please Check the Following that Apply to Your Patient's History/ Current Presentation:

High Risk Behaviours	**Present**	**Past**	**Never**	**Details:**
Suicide attempts				
Suicidal ideation				
Self-Harm behavior				
Homicidal ideation				
Violence, Acts of Aggression				
Criminal charges Probation				
Substance abuse (alcohol & drugs)				
Psychosis/Thought Disorder				

If you are requesting Rapid Response Services (patient contacted in two working days), your patient

- ☐ Suicidal/ homicidal with intent or plan, but able to manage safely in the community until seen (if unable to do so, please consider directing your patient in WRHN Emergency Room).
- ☐ Suicidal/homicidal thoughts without intent or plan but with:
  - ( ) History of past rapid decompensation
  - ( ) Marked psychosocial stressors
- ☐ Acute psychiatric impairment such as mania, psychosis, severe depression that if not urgently evaluated may result in acute decompensation or risk to self/others.
- ☐ List any other concerns for consideration of an urgent response: _____

_____

Medical Information:

Medication: No ( ) Yes ( ) Specify current and past medications: _____

_____

_____

Past medical history: No ( ) Yes ( ) Specify: _____

_____

_____

Access to Mental Health Supports/ Services:

Past mental health treatment/diagnosis/admissions: No ( ) Yes ( ) Specify: _____

_____

_____

Current mental health support: No ( ) Yes ( ) Specify: _____

_____

_____

Referral Question to be addressed by Child and Adolescent Outpatient Psychiatry:

_____

_____

_____

***Please complete the referral in full as this can affect how timely the referral is processed.**

***If any clarification is needed regarding your referral call 519-749-4300 ext. 3863. Referrals are received Monday to Friday between 8:30 a.m. and 4:00 p.m.**

Ensure supporting documentation you have available is faxed with this referral form.

Thank you for completing the referral form