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

Request for Child and Adolescent Outpatient Mental Health Services

Services are provided to individual's 6 to 17 years who reside in the Grand River Hospital 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:_____________________________ ____	Verbal consent obtained from parent: No ( ) Yes ( ) If no, please explain:_____________________________ ____
Parent/guardian information: same as child □ Name(s)__________________________________	Parent/guardian information: same as child □ Name_____________________________________
Address___________________________________ City:__________________ Postal Code:_________ Phone: Home __________ Cell : _______________	Address___________________________________ City:__________________ Postal Code:__________ Phone: Home __________ Cell : ________________
Confidential message can be left at home: No ( ) Yes ( )	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 <u>MUST</u> meet one or more of the following criteria below. Please check applicable boxes.

- ☐ 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 GRH 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:____

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Medical Information:

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

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

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Access to Mental Health Supports/ Services:

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

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

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

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***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