BRANTFORD GENERAL HOSPITAL OUTPATIENT MENTAL HEALTH
CHILD AND ADOLESCENT (5-18yrs) PSYCHIATRY CLINIC

T: 519-752-7871 EXT 5530 F: 519-751-5548

PRIVATE AND CONFIDENTIAL

This referral form is intended ONLY for use with the CHILD AND ADOLESCENT Psychiatry Clinic

For all other referrals, please visit our website; Mental Health and Addiction - BCHS (bchsys.org)

CRITERIA FOR CHILD AND ADOLESCENT PSYCHIATRY PROJECT

- Referred by MD, NP, or /and Registered Health Care Provider who is working with patients' care team
- Symptoms fall between moderate to severe impairing one's ability to function effectively
- Require a crucial and timely consultation to facilitate psychiatric assessment, initiate treatment plan, provide consultation for medication intervention and/or adjustment
- Make treatment recommendations to primary care providers and/or provide consultation on the care being provided by primary care providers
- A psychiatry referral made through traditional referral pathway will not meet the needs due to risk, acuity, and functioning.

INFORMATION FOR REFERRAL SOURCE	INFORMATION FOR INDIVIDUALS BEING REFERRED
• Information that is marked 'required' on the referral form must be completed in full. • Information requested in the referral form may be sent as an attachment with the referral if sufficient space is not provided. • Please note, referrals will not be accepted for Mental Health Outpatient Counselling Services. Please note that children age 0-14 will be referred to Woodview or other community partner based on individuals need. • The referring provider must inform whether subsequent referrals were made to similar programs to avoid duplication. **** If a referral needs to be cancelled for any reason, please contact our office to inform us of the change in status ****	• The referred Child and Family must be aware that a Psychiatric Consultation Referral Form is being completed. If not, please provide explanation on referral. • Appointment booking will be communicated through telephone to the patient/caregiver and via fax to the referral source. • If an individual's contact information changes, it is both the individual and the referring provider's responsibility to update the contact information provided. • BCHS Staff will make two attempts to contact the individual, by voicemail and/or letter, when consent is provided. If the individual cannot be reached, referral source will be notified. • Appointments MUST be cancelled 48 hours prior to scheduled visit. • Individuals can call Outpatient Mental Health Services to receive an update on the status of their referral.

HOW TO SUBMIT A SPECIALIZED REFERRAL

- Please fax to Outpatient Mental Health OR Email Mental Health Referral mhreferrals@bchsys.org
- Please ensure each referral is faxed individually.
- To help us provide the best care possible, please complete **BOTH** pages of the referral form and include **all relevant documents**, such as previous psychiatric consultations, discharge summaries, medication administration records, psychological/mental health notes, lab and test results, and medical information.

**** Please note that referrals that do not have sufficient information and/or are not completed will be sent back to the referral source requesting additional information. If we are unable to obtain additional information, this may result in the referral being closed. We welcome another referral to be sent once sufficient information is obtained ****

This form is NOT to be used for urgent psychiatric consultation. If you are concerned about acute safety issues for your patient (e.g., suicidal ideation), please contact your local crisis service or direct your patient to the nearest Emergency Room

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Patient ID Label

REASON FOR REFERRAL & GOALS - *REQUIRED*

PSYCHIATRY CONSULTATION PROGRAM

GOAL(S) FOR CONSULTATION *(e.g. diagnostic clarification, medication review, treatment recommendations, etc.):*

Priority: Urgent Moderate Routine

PATIENT INFORMATION- *REQUIRED* (Please provide the most current information)

Is patient aware/supportive of this referral? Yes No (if no, please explain) _____

Legal Name: _____ **D.O.B:** _____ **Age:** _____

Preferred Name (if different from above): _____ **Gender:** _____ **Sex:** _____

Health Card Number: _____ _____ **Family Physician:** _____
VC

Address: _____ _____ _____ _____
Street | Town/City & Province | Postal Code | Unit #

Telephone: (#1)_____(#2)_____ **Consent to Voicemail: Yes No**

Parent/Guardian Email: _____ **Consent to Email**: **Yes No**

Parent/Guardian Information: _____

Special Considerations (e.g. interpreter, accessibility needs, etc.): _____

REFERRAL SOURCE INFORMATION- *REQUIRED*

We *REQUIRE* the referring physician or the individual's MRP to continue to be available for ongoing medical care
I will continue to provide medical care and ongoing follow-up to this patient Yes No - *REQUIRED*

☐ **Family Physician**
☐ **ED or Walk-In Clinic Physician**
☐ **Pediatrician**
☐ **Psychiatrist**
☐ **Other:**

Name		
Billing # (if applicable)		
Organization		
Address		
Phone & Fax #	**P:**	**F:**
Email		

Counselling and Treatment Provider

Counsellor /Clinician	Consent	Contact information and other details
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	

PRESENTING CONCERNS- *REQUIRED* (please attach if details are expansive of the space provided)

Please provide a brief narrative explaining presenting concerns and symptoms, including duration and frequency of symptoms, psychosocial factors, substance use issues, and ***all*** other current and historical information that is relevant:

Services Currently Involved with Child/Family and other care providers- *REQUIRED*(attach notes if applicable)

Organization	Current	Describe Involvement
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	

RISK ISSUES

☐ **Recent Suicide Attempt** ☐ **Active self-harm behaviour** ☐ **Violence or aggression** ☐ **Legal Involvement**

Please complete to ensure priority/urgent booking needs are met

MEDICAL/PHYSICAL HEALTH- *REQUIRED*

Please provide a list and details of any relevant medical/physical health considerations (e.g. specific illnesses, chronic pain, difficulty coping with medical illness, etc.)

☐ **Potential organic causes for symptoms have been ruled out (e.g. thyroid issues, medication, head injury, etc.)**

MEDICATIONS- *REQUIRED* ☐ attached

**** Please include both psychiatric and non-psychiatric medication, including *all* current and previously trialed medications. Please attach medication list if medications are expansive of the space provided ****

Medication	Current	Dose	Frequency	Response/Adverse Effects
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			

SUPPLEMENTAL INFORMATION (please attach if applicable)

PHQ-9 **(REQUIRED)** ☐ attached
GAD-7 **(REQUIRED)** ☐ attached
SNAP-IV (If queary ADHD Required) ☐ attached
Mental Health Crisis Assessment ☐ attached
Hospital Discharge Summaries ☐ attached
Psychiatric Hospitalization(s) ☐ attached
Recent laboratory results (e.g. blood work, urinalysis) Other ☐ attached
Assessments (e.g. MMSE, DOS, GAIN-SS) IEP/ P – if applicable ☐ attached
☐ attached