



**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 \(bchsys.org\)](http://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
<ul style="list-style-type: none"> <li>• Information that is marked 'required' on the referral form must be completed in full.</li> <li>• Information requested in the referral form may be sent as an attachment with the referral if sufficient space is not provided.</li> <li>• 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.</li> <li>• The referring provider must inform whether subsequent referrals were made to similar programs to avoid duplication.</li> </ul> <p><b>** If a referral needs to be cancelled for any reason, please contact our office to inform us of the change in status **</b></p>	<ul style="list-style-type: none"> <li>• The referred Child and Family must be aware that a Psychiatric Consultation Referral Form is being completed. If not, please provide explanation on referral.</li> <li>• Appointment booking will be communicated through telephone to the patient/caregiver and via fax to the referral source.</li> <li>• If an individual's contact information changes, it is both the individual and the referring provider's responsibility to update the contact information provided.</li> <li>• 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.</li> <li>• Appointments MUST be cancelled 48 hours prior to scheduled visit.</li> <li>• Individuals can call Outpatient Mental Health Services to receive an update on the status of their referral.</li> </ul>

**HOW TO SUBMIT A SPECIALIZED REFERRAL**

- Please fax to Outpatient Mental Health OR Email Mental Health Referral [mhreferrals@bchsys.org](mailto: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**



**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
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> 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
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			

**SUPPLEMENTAL INFORMATION** (please attach if applicable)

- 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