SickKids® | Garry Hurvitz Centre for Community Mental Health

EXTERNAL PHYSICIAN REFERRAL FORM

If you have any questions about the referral process, please call MHAP team at 416-924-1164 ext8708

INFORMATION FOR REFERRING PHYSICIANS

- Once a referral is received, parents/caregivers or youth will complete a screening call with one of our access workers in the Mental Health Access Program (MHAP) to determine eligibility for services with our Centre
- Our team will make a referral to either assessment or treatment services
- We do not provide psychoeducational assessments as a stand alone service, nor do we provide assessment or treatment services where the primary diagnosis is psychosis, substance abuse or eating disorders
- Children diagnosed with autism spectrum disorder (ASD) should first be referred to an agency that specializes in this area. We do not provide assessments to diagnose ASD. If children have received ASD specific services and are presenting with mental health concerns, please connect with our agency to discuss

INFORMATION FOR YOUR PATIENT

- Please ensure that your patient is aware and has consented to the referral
- A staff from the MHAP team will call the parent/guardian or youth to schedule a call with the parent or guardian by phone, video conference or in person, whichever they prefer
- The MHAP team will make two attempts to contact the patient and leave two voicemails when consent is provided. If the patient cannot be reached, the referring provider will be notified.
- Given GH-CCMH is an academic and research centre, your patient may be invited to participate in research opportunities. They do not need to accept.
- Given GH-CCMH is a teaching and training centre, your patient can expect to have residents or students involved in their care.

HOW TO SUBMIT A REFERRAL:

- **Please fax the completed GH-CCMH referral form to: Mental Health Access Program 416-924-8208**
- Please ensure each referral is faxed individually.
- To help us provide the best care possible, include relevant documents, such as previous psychiatric consultation or discharge summaries, medication sheets, psychological reports

If your patient needs immediate help, please direct them to the nearest emergency department or call 911

440 Jarvis St.
Toronto, Ontario
Canada M4Y 2H4

1645 Sheppard Ave. W.
Toronto, Ontario
Canada M3M 2X4

www.sickkidscmh.ca

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BARCODE

EXTERNAL PHYSICIAN REFERRAL FORM

REFERRAL STATUS UPDATE (GH-CCMH use only)	
Assigned MHAP/Admin worker:	**Contact Info:**
☐ **Accepted for services:**	
☐ **Referred out:** ☐ Out of catchment ☐ Over 18 years old ☐ Other:	☐ Recommended resources: _____

Date of Referral (DD/MMM/YYYY): _____

PATIENT INFORMATION		
Legal name First Name:	Last Name:	**Chosen/Preferred name** (if applicable)
Date of birth (DD/MMM/YYYY):	**Health card number:** **Expiration date (DD/MMM/YYYY):**	**Version code:**
Patient address: Address: City:	Province:	Postal code:
Is there a need for an interpreter? ☐ Yes ☐ No	If yes, please specify which language:	

PATIENT CONTACT INFORMATION		
Name:	**Relationship to client:**	**Tel #1:**
Name:	**Relationship to client:**	**Tel #2:**
E-mail address:		

REFERRING PROVIDER INFORMATION		
Name First name:	Last name:	
Billing number:		
Referring provider address: Address: City:	Province:	Postal code:
Telephone:	**Fax:**	**Email:**

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1. REASON FOR REFERRAL	
Please indicate the primary reason for referral (specify current symptoms, presenting problems and history)	**Please select the service you're seeking for your patient:** ☐ Therapy/Counselling ☐ Psychiatry consultation • Medication • Diagnostic assessment ☐ Other:

2. RELEVANT MENTAL HEALTH/MEDICAL/DEVELOPMENTAL HISTORY (e.g. mental health diagnosis and history, family stressors relevant physical health issues, diagnosis of autism, intellectual delay, allergies, previous mental health assessments or other issues)

3. RISKS AND SAFETY CONCERNS

This information is used to optimally plan for the patient's first appointment and to ensure their safety and the safety of our staff.

Risk:	Yes	No	If yes, past or present concern (Details)
Suicide attempt/ideation	☐	☐	
Deliberate self-harm	☐	☐	
Harmful behaviour toward other or environment	☐	☐	
Risk-taking behaviours	☐	☐	
Limited access to community resources	☐	☐	
Substance use	☐	☐	

4. MEDICATION (both psychiatric and non-psychiatric medication)

*Please note whether any of the medications are prescribed by a physician other than yourself

Medication	Current	Dose	Frequency	Response and adverse effects
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			

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