SickKids | Garry Hurvitz Centre for Community Mental Health

BARCODE

PSYCHIATRY CONSULTATION REFERRAL FORM

Please note - We are unable to provide consultation for: ASD diagnosis; primary substance use problems; psychosis; eating disorders; primary forensic concerns; or child custody/access cases

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: **Version code:**

Expiration date (DD/MMM/YYYY):

Patient address:
Address: City: Postal code:

Legal guardian(s)
Name: Relationship to patient: Tel #1:
Name: Relationship to patient: Tel #2:

Is there a need for an interpreter? ☐ Yes ☐ No If yes, please specify which language:

REFERRING PHYSICIAN INFORMATION

Name
First name: Last name:

Billing number: **Telephone:** **Fax:**

Referring provider address:
Address: City: Postal code:

REASON FOR REFERRAL

Please indicate the primary reason for referral and if there are any risks and/or safety concerns (specify current symptoms, presenting problems and history)

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)

Current medication - both psychiatric and non-psychiatric medication (please list all medications, dose and frequency)

Please fax the completed GH-CCMH referral form to: Central Scheduling 416-874-6271

To help us provide the best care possible, please include relevant documents, such as previous psychiatric consultation or discharge summaries, medication sheets, psychological reports