# Huron Perth Healthcare Alliance
# Child and Adolescent Psychiatry Program Referral Form

We have transitioned to a Stepped Care Model for Outpatient Mental Health Services referrals. Services will be offered based on appropriateness, availability, and may include psychiatric consultation and short-term treatment, where appropriate.

## Information for Referral Source

- A referral from a Primary Care Provider (Physician, Pediatrician, or Nurse Practitioner) is ***required*** for Psychiatry
- Individual must have a Primary Care Provider (Physician, Pediatrician or Nurse Practitioner) who can provide metabolic monitoring
- Information marked "required" on the referral form must be completed in full
- Information requested in the referral form may be sent as a separate attachment if there is insufficient space on the referral form
- The referral source must inform whether subsequent referrals were made to similar programs to avoid duplication
- Right service connection will be facilitated following an intake assessment
- Communication regarding service connection will be provided to the referral source via fax and/or telephone

**Note**: if a referral needs to be cancelled for any reason, please contact Central Intake at 519-272-8210 extension 2570 or by fax 519-272-8226 to inform us of the change.

## Information for Individuals Being Referred

- The individual being referred and/or Substitute Decision Maker/Caregiver must be aware of the referral to the Huron Perth Healthcare Alliance (HPHA) Child and Adolescent Psychiatry Program
- Appointment booking will be communicated via telephone to the patient and/or their Substitute Decision Maker/Caregiver via fax to the referral source
- If an individual's contact information changes, they and/or their Substitute Decision Maker/Caregiver are responsible to notify the program or their Mental Health Clinician.
- HPHA's Central Intake staff will make three attempts to contact the individual by telephone. If the individual cannot be reached, the file will be closed and the referral source will be notified
- Individuals can contact Outpatient Mental Health Services to receive an update on the status of their referral by calling Central Intake at 519-272-8210 extension 2570.

## How to Submit the HPHA Child and Adolescent Psychiatry Program Referral Form

- Fax the completed Referral Form to **519-272-8226** (each referral must be faxed separately)
- To help us provide the best care possible, please complete **all 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.

**Note:** HPHA Central Intake will notify the Referral Source in writing that the referral forms are incomplete and/or illegible, and provide the Referral Status of Pending Due to Incomplete Documentation notification. The Referral Source will be asked to submit any missing information within **21 days** in order for the referral to be processed by Central Intake. If the required information is not received by this date, **the referral will be closed;** you are welcome to re-refer the individual in future. Re-referrals will be processed by the date that the completed package is received, **not the date of initial inquiry.**

If an individual is in crisis, direct them to the **Huron Perth Helpline and Crisis Response Team** at **1-888-829-7484** or their nearest Emergency Department. If an individual is experiencing an emergency, **9-1-1** should be contacted.

If you have any further questions or concerns, please contact Central Intake at 519-272-8210 extension 2570.

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**Date of Referral:** _____ *(DD/MM/YYYY)* **Date Referral Received *(office use only)***: _____

**Referral and Criteria Checklist – Required** *(check all that apply)*

☐ **Psychiatry Consultation** – Child & Adolescent
- ☐ Individual is between 5 and 17.5 years of age
- ☐ Referring Physician/Primary Care Provider, Pediatrician, or Nurse Practitioner has tried previous interventions that have not been successful at stabilizing the individual
- ☐ Referring Physician/Primary Care Provider, Pediatrician, or Nurse Practitioner is willing to provide medical care and ongoing follow-up to the patient
- ☐ Resident of Huron or Perth County

**Patient Demographic Information – Required** *(please print)*

Patient's Legal Name *(first name, last name)*: _____

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

Date of Birth *(DD/MM/YYYY)*: _____ Age: _____

Sex Assignment at Birth: ☐ Male ☐ Female ☐ Intersex Gender Identity: _____ Pronouns: _____

Address: _____
(Street, Unit, Town/City, Province, Postal Code)

Telephone: _____ *(home/cell/work/other)*

Consent to contact by telephone: ☐ Yes ☐ No Consent to leave detailed voicemail: ☐ Yes ☐ No

Consent to speak with others in the household: ☐ Yes ☐ No If yes, please specify *(name/relationship)*: _____

Living Arrangements/Family Circumstances *(self, parent(s), group home, etc.)*: _____

_____

Custody Status *(16 years of age and younger)*: _____

Access Arrangement/Schedule: _____

**Patient Health Card Information - Required**

Health Card Number: _____ Version Code: _____

**Additional Considerations**

**Patient:** ☐ Mobility ☐ Audio ☐ Visual ☐ Language ☐ Interpreter Services Required

☐ Service Animal ☐ Other: _____ If yes, please explain: _____

**Caregiver:** ☐ Mobility ☐ Audio ☐ Visual ☐ Language ☐ Interpreter Services Required

☐ Service Animal ☐ Other: _____ If yes, please explain: _____

**Caregiver Information**

Name of Caregiver: _____

Relationship to Patient: _____

Telephone: _____ *(home/cell/work/other)* Consent to leave detailed voicemail: ☐ Yes ☐ No

Consent to speak with Caregiver regarding this referral: ☐ Yes ☐ No

Consent to speak with others in the home: ☐ Yes ☐ No If yes, please specify: _____

Who is making treatment decisions for this patient: _____

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Client Name *(first name, last name)*: _____

**Referral Source Information - Required**

*HPHA requires the referring Primary Care Provider (Physician, Pediatrician, or Nurse Practitioner) or the individuals Most Responsible Person to continue to be available for ongoing medical care*

☐ Physician ☐ Pediatrician ☐ Nurse Practitioner ☐ Psychiatrist

☐ Emergency Department Physician ☐ Other: _____

**I will continue to provide medical care and ongoing follow-up to this patient *(required)*** ☐ Yes ☐ No

Name: _____ FHT / Medical Clinic: _____

Address: _____

Telephone:_____ Fax:_____

Billing Number : _____ CPSO Number: _____

**If above Referring Physician is not the patient's Primary Care Provider, please indicate:**

Patient's Primary Care Provider: _____

Specialist/Other Healthcare Provider(s): _____

_____

**Presenting Concerns – Required** *(attach if details cannot fit in 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:*

**Desired Outcome – Required** *(attach if details cannot fit in the space provided)*

*Please provide a brief narrative explaining the desired outcome and any information that is relevant:*

Requested Services:

☐ Treatment Recommendations

☐ Diagnostic Clarification with follow-up as clinically appropriate

☐ Psychopharmacology Consultation with follow-up as clinically appropriate

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Client Name *(first name, last name)*: _____

**Previous Mental Health Services Involved – Required** *(attach if details cannot fit in the space provided)*

Date of Most Recent Psychiatric Assessment (if applicable): _____

Location/Physician: _____

Past Psychiatric Hospitalizations: _____

_____

Out of Home Placements: _____

_____

Does the patient have a history with the Huron Perth Helpline & Crisis Response Team and/or HPHA Mental Health Services?: ☐ Yes ☐ No ☐ Unknown

If yes, please specify: _____

_____

Patient's Current Diagnoses: _____

_____

**Service Provider Information**

Organization Name: _____

Current Involvement: ☐ Yes ☐ No

Describe Involvement: _____

_____

Organization Name: _____

Current Involvement: ☐ Yes ☐ No

Describe Involvement: _____

_____

**Risk Factors** *(if applicable)*

*Please identify any risk factors that are of concern*

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Client Name *(first name, last name)*: _____

## Medical/Physical Health - Required

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

☐ Cognitive Impairment ☐ Traumatic Birth ☐ History of Seizures
☐ Other: _____

Allergies: ☐ Yes ☐ No If yes, please specify: _____

## Medications - Required ☐ attached

*Please include both psychiatric and non-psychiatric medication (dose, frequency, adverse effects), including all current and previously trialed medications. Please attached a medication list if the medications are expansive of the space provided.*

## Supplemental Information *(please attached if applicable)*

*This information is highly valued. Please check all that are attached with this referral.*

☐ Medical/Psychological/Psychiatric History
☐ Psychoeducation Assessment / Individual
☐ Education Plan (IEP)
☐ Residential Discharge Assessment (i.e. CPRI)
☐ Recent Laboratory Results (e.g. blood work, urinalysis, etc.)
☐ Other Assessments (e.g. SNAP IV, SCARED, Columbia-SSRI)

Is the patient aware of this referral? ☐ Yes ☐ No If no, please explain: _____

Is the Substitute Decision Maker/Caregiver aware of this referral? ☐ Yes ☐ No
If no, please explain: _____

***Please note, the patient and/or Substitute Decision Maker/Caregiver must consent to a referral being made on their behalf to HPHA Outpatient Mental Health Services.***

_____
**Name**

_____ _____
**Signature** **Date** *(DD/MM/YYYY)*

Thank you for making a referral to the HPHA Child and Adolescent Psychiatry Program. Your involvement in this patient's care is important to us; if you have any questions or concerns, or wish to provide updated patient information, please contact Central Intake at **519-272-8210 extension 2570** or **by fax 519-272-8226.**