Huron Perth Healthcare Alliance
Child and Adolescent Psychiatry Program Referral Form

Information for Referral Source

- A referral from a Physician/Primary Care Provider, Pediatrician, or Nurse Practitioner is ***required*** for Psychiatry
- Individual must have a Physician/Primary Care Provider, Pediatrician or access to a 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 along with the referral if sufficient space is not provided
- The referral source must inform whether subsequent referrals were made to similar programs to avoid duplication

Please 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 their caregiver must be aware of the referral to the Huron Perth Healthcare Alliance (HPHA) Child and Adolescent Psychiatry Program
- Appointment booking will be communicated through telephone to the patient/caregiver and/or via fax to the referral source
- If an individual's contact information changes they 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 call Outpatient Mental Health Services to receive an update on the status of their referral

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

- Please fax the completed Referral Form to **519-272-8226**
- Please ensure that each referral is faxed individually
- 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.

Please note: Incomplete and/or illegible referral forms will receive Referral Status of Pending Due to Incomplete Documentation notification. HPHA Central Intake will notify the Referral Source of this in writing. 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.**

HPHA Outpatient Mental Health Services does not provide urgent psychiatric consultations or intake assessments. If your patient is at imminent risk, please direct them to their nearest Emergency Department and/or the **Huron Perth Helpline and Crisis Response Team** at **1-888-829-7484**. If an individual is experiencing an emergency, please dial **9-1-1**.

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

Huron Perth Healthcare Alliance
Child and Adolescent Psychiatry Program Referral Form

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

☐ **Psychiatry** – 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
- ☐ Individual is a permanent resident of Huron or Perth County

Patient Information – Required *(please print)*

Date of Referral: _____ (DD/MM/YYYY) Completed by: _____

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

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

Health Card Number: _____ Version Code: _____

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: _____ Gender Identity: _____ Pronouns: _____

Sex: *The classification of people as male, female or intersex. Sex is usually assigned at birth and is based on an assessment of a person's reproductive systems, hormones, chromosomes and other physical characteristics. Source: Rainbow Health Ontario*

Gender Identity: *A person's internal and individual experience of gender. It is a person's sense of being a woman, a man, both, neither, or anywhere along the gender spectrum. A person's gender identity may be the same as or different from their birth-assigned sex. A person's gender identity is fundamentally different from and not related to their sexual orientation. Source: Rainbow Health Ontario*

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

Consent to mail correspondence: ☐ Yes ☐ No

Residence Phone: _____ Mobile: _____

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: _____

Consideration of Diversity:

Patient: ☐ Mobility ☐ Audio ☐ Visual ☐ Speech ☐ Interpreter Services Required

☐ Service Animal ☐ Transportation Support Required ☐ Other: _____

Caregiver: ☐ Mobility ☐ Audio ☐ Visual ☐ Speech ☐ Interpreter Services Required

☐ Service Animal ☐ Transportation Support Required ☐ Other: _____

Huron Perth Healthcare Alliance
Child and Adolescent Psychiatry Program Referral Form

Caregiver Information

Name of Caregiver: _____

Relationship to Patient: _____

Residence Phone: _____ Mobile: _____

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

Consent to leave detailed voicemail: ☐ Yes ☐ No

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

Who is making treatment decisions for this patient: _____

_____

_____

Referral Source Information - Required

Physician/Primary Care (PCP) Provider

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

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

☐ Physician/Primary Care Provider ☐ Pediatrician ☐ Nurse Practitioner ☐ Psychiatrist

☐ Emergency Department Physician ☐ Other: _____

Name: _____ FHT / Medical Clinic: _____

Address: _____

Telephone: _____ Fax: _____

Billing Number *(if applicable)*: _____ 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 *(please attach details that 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:

Huron Perth Healthcare Alliance
Child and Adolescent Psychiatry Program Referral Form

Desired Outcome – Required *(please attach details that 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

Previous Mental Health Services Involved– Required *(please attached notes if expansive of 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: _____

_____

Huron Perth Healthcare Alliance
Child and Adolescent Psychiatry Program Referral Form

Risk Factors *(if applicable)*

Please identify any risk factors that are of concern

Medical/Physical Health - Required

Please provide a list and details of any relevant medical/physical considerations

☐ 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 and may be requested for certain programs

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

_____ _____

Name *(PCP)* **Date** *(DD/MM/YYYY)*

_____

Signature *(PCP)*

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 client information, please contact Central Intake at **519-272-8210 extension 2570** or **by fax 519-272-8226**