North Bay Regional Health Centre

Child and Adolescent Psychiatry
Outpatient Consultation

- Please fax form to (705) 495-7836 -

Referral Source:
☐ Family Physician ☐ Pediatrician ☐ Nurse Practitioner ☐ ED physician
Name: _____
OHIP billing number: _____
Phone #: _____ Fax #: _____
Address: _____

Patient information:
Name: first _____ last _____
DOB: _____ (DD/MM/YYYY) Preferred pronoun: _____
Health Card #: _____ Version Code: _____
Address: _____
Phone #: _____ E-mail: _____
School: _____ Grade: _____

Reason for referral:
☐ Diagnostic clarification ☐ Management suggestions ☐ Medication issues

Please provide details:

Caregiver/legal guardian information:
Name: first _____ last _____
Name: first _____ last _____
Contact information if different from above: _____
_____
Other custody/care arrangements: _____
_____

Current mental health resources:
(1) Counselling/psychotherapy: _____
(2) CAS: _____
(3) Psychiatrist: _____
(4) Other: _____

Medications:
Current psychiatric medication:
(1) _____ (2) _____
(3) _____ (4) _____
Current non-psychiatric medication:
(1) _____ (2) _____
(3) _____ (4) _____
Past psychiatric medication:
(1) _____ (2) _____
(3) _____ (4) _____
Current Medical Issues:
(1)_____ (2) _____
(3)_____ (4) _____

Relevant investigations (with date)**:**
Height/weight/BMI: _____
BP/HR: _____
Bloodwork: date_____ pathological findings: _____
CT/MRI head: _____
EEG: _____
Psycho-educational/-metric testing: _____
Other: _____
_____
_____
_____
* Please attach any relevant findings and consultation notes to this referral if they are not available in our computer system

IMPORTANT INFORMATION:

- Follow-ups will be arranged at the discretion of the psychiatric team and based on capacity and severity of symptoms.
- All referrals will be triaged within 14 days and a notification to the referring clinician and the patient/caregiver will be sent out within this time frame.
- **For more urgent issues, please direct the patient to the nearest ED or provide them with the contact of the Kids Help Phone (Call 1-800-668-6868 or text CONNECT to 686868)**
- It is the responsibility of the referring clinician to ensure informed consent for this referral. This includes also informing the patient that a referral for consultation is not a guarantee to be seen. We recommend filling out this referral form together with the patient and the caregiver(s).

FOR INTERNAL PURPOSES ONLY:

Date (DD/MM/YYYY):	
Referral received:	
Referral triaged:	
Patient contacted:	
Patient's appointment:	

Appointment:	
Virtual or in person:	
Physician:	
No Show:	
Follow-up:	

Triage:	
Urgent:	
Semi-Urgent:	
Not Urgent:	
Declined:	