

# North Bay Regional Health Centre

Child and Adolescent Psychiatry

## Referral Form

Please fax form to (705) 495-7836

Referral to:

General Outpatient Clinic

Urgent Consult Clinic\*

ADHD Clinic\*\*

\*Only accessible to ED physicians at NBRHC

\*\*only accessible for patients aged 6-13

**Referral Source:**

Family Physician  Pediatrician  Nurse Practitioner  ED physician

Name: \_\_\_\_\_

OHIP billing number: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Address/Hospital: \_\_\_\_\_

**Patient information:**

Name: first \_\_\_\_\_ last \_\_\_\_\_

DOB: \_\_\_\_\_ (DD/MM/YYYY) Preferred pronoun & name: \_\_\_\_\_

Health Card #: \_\_\_\_\_ Version Code: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ E-mail: \_\_\_\_\_

**Parent/caregiver/legal guardian information:**

Name: first \_\_\_\_\_ last \_\_\_\_\_

Contact information if different from above: \_\_\_\_\_

**Reason for referral:**

Diagnostic clarification  Management suggestions  Adverse effects of medication  Other

Please provide details: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Psychiatric Medications (name and dose):**

Current:

(1) \_\_\_\_\_ (2) \_\_\_\_\_

(3) \_\_\_\_\_ (4) \_\_\_\_\_

Past:

(1) \_\_\_\_\_ (2) \_\_\_\_\_

(3) \_\_\_\_\_ (4) \_\_\_\_\_

**Relevant medical issues/investigations:**

The patient has received a medical workup including relevant bloodwork and appropriate investigations. I confirm that the referring symptoms are not secondary to a medical or neurological cause.

The patient has the current medical issues relevant to the presenting symptoms: \_\_\_\_\_

**Current use of substances\*:**

The patient does not use cannabis, alcohol, or other substances on a regular basis

The patient has the current use pattern (substance, frequency, amount):

Alcohol: \_\_\_\_\_

Cannabis: \_\_\_\_\_

Other: \_\_\_\_\_

\* If the primary concern is substance use or substance use is daily, please connect the patient with local addiction services

