



*Mental Health Services*  
**Child and Adolescent Psychiatric Clinic**  
**Telephone: (905) 631-0694 Fax: (905) 631-5804**

Referral Date: \_\_\_\_\_

Referral Source: \_\_\_\_\_

Referring Physician's Billing #: \_\_\_\_\_

Physician's Telephone #: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Home Telephone #: \_\_\_\_\_

Address/City/Town: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Next of Kin: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Hospital Unit ID # (if known): \_\_\_\_\_ OHIP # & Version Code: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Office Telephone #: \_\_\_\_\_ Office Fax #: \_\_\_\_\_

School & Telephone Number: \_\_\_\_\_ Access to EAP: ☐ Yes ☐ No

Reason for Referral: ☐ Behaviour Disorders of Childhood and Adolescence ☐ Mood Disorder  
☐ Anxiety Disorder ☐ Adjustment Reaction ☐ Substance Abuse  
☐ Psychosis ☐ Eating Disorder ☐ Developmental Delay  
☐ Other

Current Symptoms & Stressors: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Current Counselling & Medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Past Psychiatric Treatments/Hospitalizations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Present Medical Illness & List of Medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of Referring Physician: \_\_\_\_\_

- Please attach copies of any available reports.
- This Clinic is not able to provide any correspondence for court purposes.
- Please ensure all referrals are aware they must attend their scheduled appointments, if unable to attend we require 48-hour notification. Failure to comply with this and/or not attending the scheduled appointment without any notification may result in this referral being closed.