Contact NIAGARA
For Children's and Developmental Services
pour les services à l'enfances et d'adaptation

Physician Referral Form

Contact Niagara – The access point for child and youth counselling/psychiatry referral services within the Niagara Region. Our intake process will ensure your referral will be directed to the appropriate services
FAX: 905-684-2728

Patient's Personal Information

Patient's Name :		Health Card Number :
Address :	City :	Postal Code -
Telephone : - -	Cell : - -	Other : - - (choose)
DOB : / /	Age :	Gender : ☐ Female ☐ Male
Mother's Name :		Father's Name :
Resides with : (Choose)		
Family Physician :		Telephone : - -
Psychiatrist :		Telephone : - -

Referral Information

Referred by :	Date :	Physician's Billing # :

Reason for Referral

Intervention Requested ☐ **Psychiatric Consult** ☐ **Diagnostic Clarification** ☐ **Medication follow-up** ☐ **Counselling**
Additional Comments

Behaviour Issues

Violent or Dangerous Behaviour :	☐ Current	☐ Previous	☐ Within the last year
Threat to Self/Attempted Suicide :	☐ Current	☐ Previous	☐ Within the last year

Medication **List of Current Medications - <u>Please print clearly</u>**

Name of Medication	Dosage	Frequency
Allergies		

Consent and Agreement

I/, WE THE UNDERSIGNED AGREE TO THE EXCHANGE OF INFORMATION BETWEEN _____ AND CONTACT NIAGARA. I ALSO AGREE TO A RESOURCE COORDINATOR CALLING ME FOR THE PURPOSE OF COMPLETING AN INTAKE.

_____ _____

SIGNATURE DATE