SickKids®

LAST NAME	(FIRST)
MRN	VISIT NUMBER
DATE OF BIRTH YYYY-MM-DD	SEX
ADDRESS	

IMPRINT OR ENTER DETAILS BY HAND

TeleLink Mental Health Program

Referral Form

Agency Client #: ____________________ MRN:______________________ Date of Request:___________________
YYYY - MM - DD

Referring Agency/Hospital/Physician: ____

Location:____Telephone #:_______________________

Fax # Report is to go to (1# per agency / location): ____

Case Manager:____

Severity scale prior to service as per case manager**:** ☐ 1 ☐ 2 ☐ 3 ☐ 4

☐ First Consultation ☐ Follow Up
☐ Professional-to-Professional Consultation ☐ Re-Assessment (If the date of original consultation is 1 year or more prior to this request)

Dates Not Available:____

____

Family Doctor or Paediatrician:____
Address:____ City:_______________________ Postal Code:_________
Telephone #:______________________________________ Fax #:____
Institution/Hospital: _______________________________ Address (if different): ____________________________
City:___________________ Postal Code:____________ Physician Billing Number: ____________________________
MRP: ☐ Yes ☐ No If No, please list: ____

Information that is mandatory for referral to proceed
☐ Consent form ☐ Case Summary / Assessment

Information provided for consultation (if available)
☐ Admission History ☐ Police Synopsis ☐ Discharge Summary
☐ Fire setting Assessment (if applicable) ☐ BCFPI (if applicable)
☐ CAFAS (if applicable) ☐ Risk / Needs Assessment (if applicable)

Reports: ☐ Education Assessment ☐ Drug & Alcohol Assessment ☐ Psychological Assessment
☐ Speech & Language Assessment ☐ Fire setting Assessment ☐ School ☐ Relevant Medical Information
☐ Social History ☐ Previous Psychiatric Consultations or other Consultations ☐ Service Plan or Case Notes
☐ Youth Justice Court Documents (please specify) ☐ Other Behavioural Checklists: Please list

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CLIENT INFORMATION

Patient's Name:______________________ ☐ Male ☐ Female DOB:__________ YYYY - MM - DD

Address:______________________City:__________Postal Code:________

Health Card #:______________________Version:__________Exp.:__________ YYYY - MM - DD

In Patient: ☐ Yes ☐ No If Yes, please state reason: __________ ☐ Crisis ☐ Elective

Admission Date (YYYY-MM-DD):__________ Expected Discharge Date (YYYY-MM-DD):__________

Guardian Name(s):______________________

Guardian Contact #: Primary:__________Secondary:__________

Is legal guardians' address the same as clients? ☐ Yes ☐ No If No please complete address section

Address:______________________City:__________Postal Code:________

Custodial Status: ☐ Intact ☐ Joint* ☐ Sole Custody* ☐ Temporary Care Agreement
☐ Temporary Care and Custody Order ☐ Supervision Order ☐ Society Wardship Order
☐ Crown Wardship Order ☐ Child protection order for custody (s. 65.2)
☐ Customary Care Agreement ☐ Kinship Agreement
* Please provide legal documentation

Residence Information

Resides with: ☐ Bio-Mother ☐ Bio-Father ☐ Step-Mother ☐ Step-Father ☐ Same Sex Parents
☐ Adoptive Mother ☐ Adoptive Father ☐ Extended Family ☐ Independent Living
☐ Other (please explain):______________________

Please list complete names of individuals the client resides with and how they are related (i.e. sister, brother, step-father):

____

Resides where: (if other than family home)

☐ Foster Home ☐ Group Home (☐ Short-Term ☐ Long-Term) ☐ Detention Centre ☐ Secure Setting ☐Open

Custody Setting: ☐ Custody / Detention Centre Treatment Program: ☐ Yes ☐ No Other:

School Grade: _____ ☐ Regular Class ☐ Special Education ☐ Day Treatment ☐ Section 23 ☐ Not Attending

Language(s) spoken by client: ☐ English ☐ French Other:______________________

Is an interpreter required? ☐ Yes ☐ No

Language(s) spoken by parent(s): ☐ English ☐ French Other:______________________

☐ Aboriginal ☐ First Nations ☐ Metis ☐ Inuit ☐ On Reserve ☐ Off Reserve

Currently before the courts ☐ Yes ☐ No ☐ Sentenced / YJ

Explanation:______________________

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Reason for Referral: ☐ Full Consultation re: ☐ Diagnosis ☐ Medication ☐ Management:

Questions to be answered from this consultation (please be specific and attach additional information if needed):

Parent(s) / Guardian(s) Concerns (attach additional information if needed):

Medical Problems and Allergies:

Family History of Mental Illness (please specify and attach additional information if needed):

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MAJOR CONCERNS (Check those that apply)

☐ Developmental Delay ☐ FAE / FAS ☐ Socialization Problems

☐ School Problems: ☐ Academic ☐ Behavioural ☐ Truancy ☐ Other:______________________________

☐ ADHD: ☐ Inattentive ☐ Impulsive ☐ Hyperactive

☐ Oppositional Defiant

☐ Aggressive Behavior: ☐ Verbal ☐ Physical ☐ Other:______________________________

☐ Antisocial Behavior: ☐ Substance Abuse ☐ Alcohol ☐ Drug ☐ Firesetting ☐ Other:______________

☐ Conflict with the law Please specify:______________________________

☐ Sexual Acting Out: ☐ Current ☐ Past Please Specify:______________________________

☐ Mood Problems: ☐ Depression ☐ Mood Swings ☐ Elevated Mood

☐ Suicidal Behaviors: ☐ Current ☐ Past Please Specify:______________________________

☐ Self-Harm: Type: Please Specify:______________________________

☐ Anxiety ☐ Obsessions ☐ Compulsions ☐ Worry ☐ Avoidant Behavior

☐ Somatization ☐ Sleep Problems

☐ Eating Disorder: Please explain______________________________

☐ Family Conflict: ☐ Separation from Parents / Family ☐ Grief ☐ Other:______________________________

☐ Strange, Bizarre Behavior: ☐ Hallucinations ☐ Delusions

☐ Witnessed Traumatic Events: ☐ Physical ☐ Emotional ☐ Sexual

☐ Experienced Trauma: ☐ Physical ☐ Emotional ☐ Sexual

Interventions: ☐ None Currently ☐ No previous Agency involvement

Counselling: ☐ Individual ☐ Family ☐ Parent ☐ Group ☐ Other:______________________________

1. Involved in Specialized Program:______________________________

2. Had Previous Mental Health Assessments e.g. psychiatric, psychological, TAPP-(C), etc., (Not Telepsychiatry)

☐ No ☐ Yes Date:________________ By Whom:______________________________
YYYY - MM - DD

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3. Is this child/youth currently involved with any other Mental Health Agency or Psychiatrist?

____

4. Current Medications

☐ Stimulant
Name and Dosage:____________________
Name and Dosage:____________________
Name and Dosage:____________________

☐ SSRI or other Anti-Depressant
Name and Dosage:____________________
Name and Dosage:____________________
Name and Dosage:____________________

☐ Mood Stabilizer
Name and Dosage:____________________
Name and Dosage:____________________
Name and Dosage:____________________

☐ Anti-Psychotic
Name and Dosage:____________________
Name and Dosage:____________________
Name and Dosage:____________________

☐ Anti-Anxiety
Name and Dosage:____________________
Name and Dosage:____________________
Name and Dosage:____________________

☐ Other meds
Name and Dosage:____________________
Name and Dosage:____________________
Name and Dosage:____________________