SHN
SCARBOROUGH HEALTH NETWORK

SHONIKER CLINIC REFERRAL FORM
Child & Adolescent Outpatient Mental Health
2877A Ellesmere Road, Scarborough, ON M1E 4C1
Phone: 416-281-7301 • **Fax:** 416-281-7465
Email: shonikerclinic@shn.ca

Please note:
We accept patients under 19 within the following catchment area: Ajax, Pickering, and Scarborough (only postal codes starting with M1_)

The Shoniker Clinic does not accept the following referrals: Eating disorders, educational or psychological testing, developmental assessments, assessments for court purposes; and/or cases with unresolved custody/access issues.

For first episode psychosis patients please fill out the F.I.T.T. Referral Form.

APPOINTMENTS ARE SCHEDULED DIRECTLY WITH PATIENTS & PARENTS

Date: _____

Patient Demographics:

Last Name: _____ First: _____ Person to Contact: _____

Address: _____ Relationship to Patient: _____

Postal Code: _____ Home Tel #: _____

DOB (D/M/Y): _____ Gender: _____ Work #: _____

Patient's Tel #: _____ Cell #: _____

OHIP#: _____ VC: _____

Referral Source:

Physician Name: _____

Tel#: _____ Fax #: _____

Billing # _____

Name of GP (if different from above): _____

Service Requested:

	Yes	No
Diagnostic Assessment:	☐	☐
Medication Consult:	☐	☐
Counselling:	☐	☐

Other: _____

Reason for Referral:

	Mild	Moderate	Severe		Mild	Moderate	Severe
Addictions	☐	☐	☐	Depression Symptoms	☐	☐	☐
ADHD Symptoms	☐	☐	☐	Behavioural Issues	☐	☐	☐
Anxiety Symptoms	☐	☐	☐	Psychosis Symptoms	☐	☐	☐
Developmental Issues	☐	☐	☐	PTSD Symptoms	☐	☐	☐
Self-Harm/Suicidal Ideation	☐	☐	☐	School Issues	☐	☐	☐

Other: _____

Relevant Medical History: _____

_____

Current Medication(s)/Treatment: _____