



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

APPOINTMENTS ARE SCHEDULED DIRECTLY WITH PATIENTS & PARENTS

Date: _____

Patient Demographics:

Last Name: _____ First Name: _____

DOB (D/M/Y): _____ Gender: _____ OHIP #: _____ VC: _____

Address: _____ Postal Code: _____

Patient Cell #: _____ Patient Home #: _____

Patient Email: _____

Guardian Name: _____ Relationship: _____ Guardian #: _____

Guardian Email: _____

Referral Source: **Please note that referrals to the Shoniker and FITT program must be from a doctor and include the billing number.*

Referred By: _____ Physician Billing #: _____

Phone #: _____ Fax #: _____ Name of GP: _____

Shoniker

(General psychiatry up to age 19)

Service Requested:

- Psychiatry
- Counselling
- Medication consult
- ADHD Assessment
- Other (please specify):

FITT

(First Intervention Treatment Team)
 (Early psychosis program, ages 14-35)
 (Catchment area: Scarborough)

Services Requested:

- Psychiatry
- Counselling
- One-time assessment
- Case management
- Other (please specify):

LINK

(A Transitional Age Youth Service providing navigational support for high-risk, complex clients ages 18-24)

Services Requested:

- Psychiatry
- Navigational support
- Other (please specify):

Reason for Referral: _____

Relevant Medical History: _____

Current Medication(s)/Treatment: _____

