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: _____

Client consents to referral ☐
Does client consent to guardian consultation/involvement with this referral? ☐ Yes ☐ No

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:
_____
_____