SHN
SCARBOROUGH HEALTH NETWORK

# Outpatient Mental Health- Child and Adolescent Program

Catchment Areas: Shoniker Clinic- Scarborough (M1 postal code) & Pickering Ajax

DBT, ADHD, LINK & FITT - Scarborough only (M1 postal code)

**This referral form is not for emergencies: We are not an emergency service.** If you are concerned that an individual is actively suicidal/homicidal, or this person's needs are too severe to wait for an assessment, please consider accessing a Psychiatric Crisis Service or the Emergency Department at the nearest hospital

## Patient Information

| | | | |
|---|---|---|---|
| Legal Name | | Preferred Name | |
| Date of Birth | | Health Card | |

| | | | |
|---|---|---|---|
| Gender | ☐ Cis-Gender ☐ Agender<br>☐ Transgender ☐ Other<br>**Preferred Pronouns:** | Biological Sex | ☐ Male ☐ Other<br>☐ Female |
| Patient Address | Address<br>City | Postal Code | Province |

## Client Contact Information

| | | |
|---|---|---|
| Telephone Number<br>☐ Home ☐ Mobile | Consent to leave message (voice or text) | ☐ Yes<br>☐ No |
| Telephone Number<br>☐ Home ☐ Mobile | Consent to leave message (voice or text) | ☐ Yes<br>☐ No |
| Client Email: | Consent to send email | ☐ Yes<br>☐ No |

## Parent or Guardian Contact Information

| | | |
|---|---|---|
| Telephone Number<br>☐ Home ☐ Mobile | Consent to leave message (voice or text) | ☐ Yes<br>☐ No |
| Telephone Number<br>☐ Home ☐ Mobile | Consent to leave message (voice or text) | ☐ Yes<br>☐ No |
| Parent/Guardian Email: | Consent to send email | ☐ Yes<br>☐ No |

| Accessibility Needs | | | |
|---|---|---|---|
| Interpreter | ☐Yes ☐No | | What Language |
| Physical Accessibility Needs: | | | Please Provide Details |

| Custody Status | | | |
|---|---|---|---|
| ☐Lives with Both Parents | ☐ Lives with Single Parent, Sole Custody | ☐ Joint Custody (both parents must consent to referral) | ☐Other: |

| Consent | | | |
|---|---|---|---|
| | **Yes** | **No** | **Unsure** |
| Patient aware and consents to referral | | | |
| For patients over the age of 16 years, patient consents to parent/guardian involvement | | | |

| Reason for Referral | Type of Service |
|---|---|
| | ☐ Shoniker Clinic (4-18 years)<br>☐ ADHD Assessment Clinic (4-17 years)<br>☐ Link Navigation (18-24 years)<br>☐ FITT Early Psychosis Team<br>☐ DBT (14-24 years) |

| Risk and Safety | | | |
|---|---|---|---|
| | Yes | No | Details |
| Suicide attempt | | | |
| Deliberate Self Harm | | | |
| Violent Behaviour/Safety Concerns | | | |
| Legal Involvment | | | |
| Substance Use Concerns | | | |
| Other: | | | |

| Medical Information | | | | |
|---|---|---|---|---|
| **Medication** | **Current/Past** | **Dose** | **Frequency** | **Prescribed By:** |
| | | | | |
| | | | | |
| | | | | |

| Other Mental Health Supports e.g.school, hospitalization, community mental health, etc | | |
|---|---|---|
| **Organization** | **Current/Past** | **Details** |
| | | |
| | | |
| | | |

| Disclaimer | |
|---|---|
| | I am aware that this psychiatric consultation does not necessarily involve ongoing treatment and that the primary care physician is expected to continue to be involved in the patient's mental health care and treatment |
| | This psychiatric consultation is not for the purpose of court order or forensic assement |
| | The patient is currently not actively being treated for an eating disorder |
| | |

| Referring Physican Information | |
|---|---|
| Name | |
| Billing Number | |
| Address | |
| Phone | Fax |