Child and Youth Specialized Psychiatric and Mental Health Services Intake Referral Form

Name of Referring Physician: _____ Date of Referral: _____

Office Address:	Office Phone:
	Office Fax:
	Billing Number:

Reason for Referral: (please check)

☐ Consultation ☐ Assessment ☐ Treatment ☐ Medication Consultation

☐ **Psychiatry Phone Consultation Only**

Patient Information:

Name:	Health Card Number:
Date of Birth:	Sex: ☐ Male ☐ Female
Address:	Home Phone:
	Cell Number:
	Parent Work Number:
Patient's Preferred Language: ☐ English ☐ French ☐ Other please indicate:	

If patient is 16 and older: ☐ parent aware of referral? ☐ patient agreeable to service?
Note: patient could be seen at the Royal Ottawa Mental Health Centre if 16 years of age and older

Parent/Guardian Information *Mandatory*: ☐ Contact patient directly

Parent/Guardian #1:	Relationship to patient:
Address: (if different from above)	
Parent/Guardian #2:	Relationship to patient:
Address: (if different from above)	

If parents are separated / divorced, who has custody:
☐ Parent #1 ☐ Parent #2 ☐ Joint Other: _____
CAS Involvement? ☐ Yes ☐ No If yes please provide contact info: _____

Presenting Problem

Please describe in detail the presenting problem:

_____

_____

Please check the relevant issues of the following and circle noted symptoms:

- ☐ Depression (sad, irritable, hopeless, poor sleep, crying, social withdrawal/isolating, lacking of interest in activities, decreased energy)
- ☐ Anxiety (worries, restless, scared, poor sleep, obsessive thoughts and/or compulsions, frequent headaches/stomach aches, frequent school absences, shy, afraid to be around others)
- ☐ Behavioural Problem (fighting, anger outbursts, arguing, truancy, destruction of property, fire setting, defiance)
- ☐ Attention/Hyperactivity Problems (difficulty sustaining attention, hyperactive, impulsive, not completing tasks)
- ☐ Abnormal Eating Behaviours (fear of weight gain, distorted body image, under eating, over exercising, binging, purging)
- ☐ Trauma Symptoms/Confirmed findings of Physical/Sexual Abuse or Neglect (nightmares, flashbacks, intrusive memories, easy startle response, sexualized behaviour)
- ☐ Developmental Concerns (cognitive, social or language impairments ie FAE, FAS, Autism, PDD)
- ☐ Psychosis (hearing voices, paranoia, delusions, hallucinations)
- ☐ Medical Concerns (pain, other somatic symptoms_____, feeding problems, elimination problems, treatment non-adherence, tics, anxiety about medical procedure, acute/chronic medical condition impacting mood/behaviour, acute/chronic medical condition impacting cognition/memory/learning)
- ☐ Other (please specify) _____

To help with the assignment of your patient, please indicate ONE problem area of primary concern.

_____

Urgency:

Danger to others:	☐ **None**	☐ **Mild**	☐ **Moderate**	☐ **Severe**
Psychotic symptoms:	☐ **None**	☐ **Mild**	☐ **Moderate**	☐ **Severe**
Substance Use:	☐ **None**	☐ **Mild**	☐ **Moderate**	☐ **Severe**
Medical condition:	☐ **None**	☐ **Mild**	☐ **Moderate**	☐ **Severe**
Non suicidal self injury:	☐ **None**	☐ **Mild**	☐ **Moderate**	☐ **Severe**
Suicidal ideation:	☐ **None**	☐ **Mild**	☐ **Moderate**	☐ **Severe**
Suicidal attempt:	☐ **None**	☐ **Mild**	☐ **Moderate**	☐ **Severe**
Suicide plan:	☐ **No**	☐ **Yes**		

If severe or yes please provide details, including how recent: **less than** 30 days, **more than** 30days, but less than 90 days, more than 90 days._____

_____

_____

Functioning:

Problems with social/friendships/community functioning/interests:

☐ **None** ☐ **Mild** ☐ **Moderate** ☐ **Severe**

Problems with school functioning:

☐ **None** ☐ **Mild** ☐ **Moderate** ☐ **Severe**

Problems with family functioning:

☐ **None** ☐ **Mild** ☐ **Moderate** ☐ **Severe**

Any known medical conditions: (please include allergies)

_____

_____

Medications – please list current medications and previous medication trials to address mental health problems:

Name of Medication	Dose

Current Mental Health Professionals/Agencies Involvement:

Please list any current mental health professionals involved with this patient or any other referrals made related to this situation

Name of Provider/ Agency	Date

Past Mental Health Professionals/Agencies Involvement:

Please list any previous mental health professionals involved with this patient

Name of Provider / Agency	Date

*****Please provide copies of any previous assessment reports*****

Any further comments regarding this referral:

_____
_____
_____
_____

Physician's signature _____

Please fax completed referral to 613-738-4235.

Please note if the referral is submitted incomplete it will be returned to you for completion.