HUMBER RIVER HOSPITAL

CONSULTATION REFERRAL FORM

CHILD AND ADOLESCENT MENTAL HEALTH PROGRAM

1235 Wilson Ave., Toronto, ON M3M 0B2

Section I: Patient Information

Date: ____/____/____ (d/m/y) **Sex** F ☐ M ☐ **DOB:** ____/____/___ (d/m/y)

PATIENT NAME (print): Last: _____ First _____

PARENT / GUARDIAN NAME: _____

ADDRESS: _____
Street City Postal Code

HOME PH#: _____ **WORK PH#**:_____ **CELL PH#:**_____

OHIP #:_____ **Version Code:** _____

School Name:_____ **Phone #:**_____

Agencies Involved? ☐ **None** ☐ **(CAS, CCAS etc or other):** _____

Section II - Services Requested

(1) Outpatient Clinic **A** ☐ **Consult only** **B** ☐ **Consult & Stabilization** **C** ☐ **Consult, stabilization & ongoing care** **Ph: 416.242.1000 ex 43170 Fax: 416.242.1024**	**(2)** ☐ **Day Treatment / Transition Program** **Ph: 416.242.1000 ex 43170 Fax: 416.242.1024**

*******WE WILL CONTACT PATIENT WITH APPOINTMENT*******

Reason for referral / Previous Diagnosis (if known / suspected): _____

_____

_____

_____

Relevant background history: _____

Any significant physical illness current/past: _____

Most recent physical assessment and findings: _____

Current medications and doses: _____

Alerts: ☐ **Allergies / sensitivities,** ☐ **Active suicidal ideation,** ☐ **Seizure,** ☐ **Severe aggression,**
☐ **Severe communication difficulties:** _____

Referring Physician: _____

Billing # _____ **Phone #** _____ **Fax #** _____

Signature: _____

FIRST CONSULTATION WILL REQUIRE A PARENT/GUARDIAN PRESENT
PLEASE FILL OUT THE FORM COMPLETELY AND CLEARLY TO FACILITATE PROCESSING

Thank you, Child and Adolescent Mental Health Program

Form # 002214 2015-11

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