SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9

Child & Adolescent Mental Health

Health Record #: _____ Complete or place barcoded patient label here

Patient Name: *(Print first, last)* _____

DOB: mm / dd / yy Age: _____ ❑ Female ❑ Male

OHIP #: _____ Version Code: _____

Account #: _____ Date of Admission: mm / dd / yy

Complex ADHD and Disruptive Behaviours Clinic Consultation Request

(Consultation Request by a Physician)

Please attach any relevant documents, e.g. psychological/school assessments and fax to (905) 830-5977.

This consultation request is for physicians' seeking diagnostic clarification for children and youth ages 6 – 18, treatment, and/or treatment recommendations for:

- Disruptive behaviour, including impulsivity, anger outbursts, oppositionality, and/or aggressive behaviours
- Primary attention problems

Eligibility for participation in the Treatment Program is to be determined following consultation and in conjunction with the Clinical Team.

Treatment Program Exclusion Criteria:

Patients better served by teams other than the Complex ADHD/Disruptive Behaviours Clinic are children/youth whose primary problem is:

- Intellectual disability
- Primary Autism Spectrum Disorder or Pervasive Developmental Disorder
- Substance use/dependence
- Traumatic brain injury
- FASD (ARND)
- Unresolved court charges
- Unresolved custody access issues
- Breakdown of parental authority such that compliance with treatment expectations is unlikely

Patient Name: *(print first, last)*		
Address:		
Date of Birth: mm / dd / yy	**Health Card Number:**	**Version Code:**

Caregiver 1 ❑ Custodial	**Caregiver 2** ❑ Custodial
Name: *(print first, last)*	**Name:** *(print first, last)*
Relationship:	**Relationship:**
Phone Number:	**Phone Number:**
Alternate Number:	**Alternate Number:**

REASON FOR CONSULTATION REQUEST:

Current medications, doses and frequency:

BY SIGNING THIS FORM, I CONFIRM THAT THIS PATIENT IS AWARE OF THIS CONSULTATION REQUEST

Referring Physician: *(print first, last)*	**OHIP Billing #:**
Signature:	**Date of Birth:** mm / dd / yy
Phone Number: ( )	**Fax Number:** ( )