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

Psychological Assessment Referral Form

Date of Referral: mm / dd / yy

CRITERIA FOR CONSIDERATION OF A PSYCHOLOGICAL ASSESSMENT:

1. **Patient must be a registered patient of southlake's Child and Adolescent Mental Health Program.**
2. Specific diagnostic questions and/or complex psychodiagnostic questions that are necessary to inform current treatment approach.
3. Can be completed in a time frame that will contribute to current treatment.
4. Cannot reasonably be completed by another agency (e.g. learning assessments should be directed to the appropriate school board or to a private practitioner if possible).

Patient Name: *(print first, last)*

Patient Address:

Date of Birth mm / dd / yy	**Health Card Number:**	**Version Code:**
Parent/Guardian(s) Name: *(print first, last)*		**Relationship:**

Home Phone Number: ❑ *Can call this number* ❑ *Can leave messages* ❑ *on voicemail* ❑ *with person*

Parent Work Phone Number: ❑ *Can call this number* ❑ *Can leave messages* ❑ *on voicemail* ❑ *with person*

Parent Cell Phone Number: ❑ *Can call this number* ❑ *Can leave messages* ❑ *on voicemail* ❑ *with person*

Is the patient and/or parent/guardian aware of the reason(s) a psychological assessment is being requested: ❑ Yes ❑ No

Primary Care Physician Name: *(if different from referring Physician) (print first, last)*

REASON FOR REFERRAL: _____

Please describe reasons for the current referral (including specific diagnostic question(s), relevant background information, observed behaviours, existing diagnoses, previous assessment results, medications etc.): _____

_____

_____

_____

_____

_____

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

Referring Clinician Name: *(print first, last)*

Program Name:	**Phone ext.:**
Referring Clinician Signature:	**Date:** mm / dd / yy

Please indicate dates/times you may be available to discuss this referral: _____

NOTE: please put a copy of this referral form in the patient's chart, please forward a copy to Child and Adolescent Mental Health Program, West 5. The psychologist will call you to briefly discuss the referral.