



596 Davis Drive
Newmarket, ON L3Y 2P9

Child + Adolescent Mental Health

Health Record #: _____	Complete or place barcoded patient label here
Patient Name: <i>(Print first, last)</i> _____	
DOB: <u>mm</u> / <u>dd</u> / <u>yy</u>	Age: _____ <input type="checkbox"/> Female <input type="checkbox"/> Male
OHIP #: _____	Version Code: _____
Account #: _____	Date of Admission: <u>mm</u> / <u>dd</u> / <u>yy</u>

Internal Referral to Outpatient Programs

Referral To: <input type="checkbox"/> Child & Family Clinic	<input type="checkbox"/> Day Hospital Program	<input type="checkbox"/> Disruptive Behaviours Program
<input type="checkbox"/> Eating Disorders Program	<input type="checkbox"/> Young Adult Eating Disorders Program	

IMPORTANT: Please print or type all required information legibly. Your patient will only be contacted once all of the information has been received.

Referrals from Outpatient Programs: Please attach any relevant external reports to the referral. Referrals to the Day Hospital Program, Eating Disorders Program and the Young Adult Eating Disorders Program will require completed medical information forms from the family physician. The referrer must advise the client's family physician that s/he will receive a medical assessment form for completion in order to activate the referral.

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

Patient Address: _____

Date of Birth <u>mm</u> / <u>dd</u> / <u>yy</u>	Health Card Number: _____	Version Code: _____
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Caregiver 1 <input type="checkbox"/> Custodial Parent	Caregiver 2 <input type="checkbox"/> Custodial Parent
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Name: <i>(print first, last)</i> _____	Name: <i>(print first, last)</i> _____
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Relationship: _____	Relationship: _____
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Home Phone Number: _____	Home Phone Number: _____
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Work Phone Number: _____	Work Phone Number: _____
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Cell Phone Number: _____	Cell Phone Number: _____
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Family Physician/NP Name: <i>(print first, last)</i> _____	Tel #: _____
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Family Physician/NP Address: _____	Fax #: _____
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Additional Copies to: _____

REASON FOR REFERRAL: _____

Current medications, doses and frequency: _____

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

Referring Clinician Name: <i>(print first, last)</i> _____	Tel. ext.: _____
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Clinician's Program: _____	Date of Referral: <u>mm</u> / <u>dd</u> / <u>yy</u>
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Referring Physician/MRP Name: *(print first, last)* _____

Referring Physician Signature: _____	Tel. ext.: _____
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Brief Program Descriptions

Child & Family Clinic for Specialized Mental Health Services: Serves children aged 6 to their 18th birthday, residing in York Region. Referrals from physicians and secondary service providers (with the family physician's approval) are accepted for children and youth with severe mental illness and / or significant difficulties in functioning. The Clinic provides outpatient services, including psychiatric assessments for all referrals, as well as intensive psychotherapy services for clients as necessary, following the psychiatric assessment.

Day Hospital Program: The program provides assessment and intensive treatment for youth aged 14 to their 18th birthday (grades 9-12) with severe psychiatric disorders who reside in York Region. The program provides day treatment services, with a Care & Treatment classroom and multidisciplinary treatment for youth and their families in the community, as well as transitional care for those patients who are receiving mental health inpatient services at Southlake Regional Health Centre. The goal of this program is to enhance functioning at home, school and in the community.

Disruptive Behaviours Program: The program is a hospital-based outpatient program for residents of York Region, serving children from 6 to their 18th birthday. Types of problems addressed include moderate to severe disruptive behaviours, oppositional defiance, explosiveness and early conduct problems. Services provided include consultative assessment, pharmacotherapy, brief intensive psychosocial treatment via individual, family and group modalities. Clients with current court involvement will not be considered for this program.

Eating Disorders Program: The program is a regional outpatient program serving youth up to their 18th birthday who live in York Region or Simcoe County. The program offers two streams of treatment services provided by a comprehensive interprofessional team: (1) an intensive Day Treatment Program for youth between the ages of 13 to their 18th birthday, offering a half-day school program and multimodal therapies, and (2) outpatient services for children and youth, which may include family and group therapies, as well as nutritional counseling, psychiatric care and family education and support.

Young Adult Eating Disorders Program: The program is a regional outpatient program for young adults between the ages of 18 and their 25th birthday, who live in York Region or Simcoe County. In order to be considered for the program, clients must be medically stable and manage their eating disorder adequately in the community. Services include a comprehensive assessment and treatment, which may include education regarding eating disorders, group therapy, individual therapy, family therapy, nutritional counseling, medical monitoring and / or psychiatric consultation.