SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9

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

Child + Adolescent Mental Health

Outpatient Programs Referral

FAX: 905-830-5977

IMPORTANT: Please print or type all required information legibly. Your patient will only be contacted once all of the information has been received. The intake worker will review all of the information and communicate with the child and/or family to determine which program best suits your patient's needs. Program descriptions and criteria for each program are on the back of this form.

Referrals for the Child & Family Clinic and Disruptive Behaviours Program: Please attach any relevant documents, e.g., psychological / school assessments, and **fax to: 905-830-5977**.

Patient's Name: *(print first, last)*		**Date of Birth:** mm / dd / yy
Patient Address: Street Number + Name	Apartment / City / Province / Postal Code	
Sex: ❑ Male ❑ Female	**Health Card #:**	**Version Code:**
Caregiver 1 Name: *(print first, last)*		❑ **Custodial Parent**
Relationship:		
Telephone Number Home:	**Alternate Phone Number:**	
Can we leave a message? ❑ Yes ❑ No	If yes, with: ❑ Person ❑ Machine ❑ Either	
Caregiver 2 Name: *(print first, last)*		❑ **Custodial Parent**
Relationship:		
Telephone Number Home:	**Alternate Phone Number:**	
Can we leave a message? ❑ Yes ❑ No	If yes, with: ❑ Person ❑ Machine ❑ Either	
Guarantor: *(if patient 15 years of age or younger)*		
Guarantor Health Card #: *(this is optional)*	**Version Code:**	**Phone Number:**
Name of Emergency Contact: *(print first, last)*		
Relationship to Patient:		**Phone Number:**
Primary Care Physician Name: *(if different from referring Physician) (print first, last)*		
Phone Number:	**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 Physician Name: *(print first, last)*	**Billing #:**
Referring Physician Signature:	**Date:** mm / dd / yy
Phone Number:	**Fax Number:**

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Child + Adolescent Mental Health

Brief Program Descriptions

Child & Family Clinic for Specialized Mental Health Services: Serves children aged 6 to 18 years of age, 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.

Disruptive Behaviours Program: The program is a hospital-based outpatient program for residents of York Region, serving children from 6 to 18 years. 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.