External Referral Form - Sunnybrook Youth Psychiatry Outpatient Program

Physician Referred To: _____ Referral Date: _____/_____/_____
DD / MM / YYYY

Patient Demographic Information

Surname (PRINT): _____ Given Name (PRINT): _____

Date of Birth: _____/_____/_____ Age: _____ Gender: ☐ Male ☐ Female ☐ Other: _____
DD / MM / YYYY

Patient Phone: (_____) _____ - _____

Address:_____

Same address as parents? ☐ Yes ☐ No

_____

(Please note that the patient's home postal code must begin with the letter 'M'.)

Health Card #: _____ VC: Children's Aid Society involvement? ☐ Yes ☐ No

Current Medications (please include dosage and duration)

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Referring Source Information

Name (PRINT): _____

Address: _____

_____

Phone: (_____) _____ - _____ ext. _____

☐

☐ Family doctor ☐ Psychiatrist ☐ Other

Billing number: _____

*** Please provide details regarding reason for referral***

_____

_____

_____

_____

_____

_____

_____

Parent Demographic Information

Name: _____

Address (if different than patient):

_____

_____

Home Phone: (_____) _____ - _____

Cell Phone: (_____) _____ - _____

e-mail: _____

Office Use Only

Referred to: _____

Appt. Date: _____/_____/_____
DD / MM / YYYY

Notes:

	Primary reason for referral: (select ONE)	Secondary reason(s): (if relevant)
Psychosis: Delusions (fixed false beliefs), hallucination Grossly disorganized/bizarre speech or behaviour	☐	☐
Depression: Persisting low/sad or irritable mood and lack of interest, guilt, suicidality, sleep/appetite changes	☐	☐
Hypo/Mania: Elevated/euphoric or irritable mood with increased activity/energy/speech/ideas, disinhibited reckless or risky behaviour, grandiosity, and/or decreased need for sleep.	☐	☐
Anxiety:	☐	☐

(If present, please specify):

- ☐ Obsessive thoughts; rituals or compulsions
- ☐ Post-traumatic stress (anxiety following traumatic event including flashbacks, re-experiencing, numbness/detachment)
- ☐ Specific or social phobia, panic attacks, or generalized

Check additional areas of concern, if relevant - the following disorders/issues should not be a primary reason for referral to our clinic, but might be comorbid/related concerns:

- ☐ **Alcohol/Drug Abuse**
- ☐ **Antisocial Behavior** – theft, assault, truancy, fire-setting, lying
- ☐ **Developmental Issues** – developmental delay/ mental retardation, autism spectrum symptoms (deficits in [or idiosyncratic/odd] speech, communication, reciprocity, mannerisms, social skills deficits, particularly with regard to reading non-verbal cues)
- ☐ **Dysfunctional Eating** – excessive dieting, starvation, compulsive exercising, bingeing and purging
- ☐ **Self-Destructive Behaviors –** self-injury (e.g. cutting), impulsivity, intense and unstable interpersonal relationships, prominent anger
- ☐ **Attention Deficit Hyperactivity Disorder** (**ADHD) –** inattention/hyperactivity or lifelong disorganization attributable to lack of focus
- ☐ **School Issues –** learning disabilities, poor grades, poor attendance, behavioral issues, social issues (e.g. bullying)
- ☐ **Other** – (e.g. anger management issues) please elaborate in the 'other' section below

****PLEASE ENSURE THIS BOX IS COMPLETED:**

Past Mental Health Treatment:

- ☐ I have forwarded all prior assessment / treatment / summary notes along with this referral to Sunnybrook Youth Office.
- ☐ No previous mental health treatment.
- ☐ Other (explain):

Family Psychiatric History

Diagnosis	1st Degree Relative	2nd Degree Relative
Depression		
Bipolar		
Anxiety		
Substance Use		
Other:		

****Fax completed form to Division of Youth Psychiatry Central Intake @ 416-480-6818****