# External Referral Form - Sunnybrook Youth Psychiatry Outpatient

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

**Patient Demographic Information**

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

Date of Birth: _____/_____/_____ Age: _____
DD / MM / YYYY

Gender: ☐ Male ☐ Female

Patient Phone: (_____) _____ - _____

Address: _____

_____

Same Address as Parents: ☐ Yes ☐ No

Parental Custody: ☐ Yes ☐ No

Health Card #: _____ VC: ____

Involved in Children's Aid Society: ☐ 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: (_____) _____ - _____

**Office Use Only**

Referred to: _____

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

Notes: _____

_____

_____

_____

# External Referral Form - Sunnybrook Youth Psychiatry Outpatient

| | 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 behavior, grandiosity, and/or decreased need for sleep. | ☐ | ☐ |
| **Anxiety (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

**Please 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

☐ I have forwarded all prior assessment/treatment/summary notes along with this referral to Sunnybrook Youth Office.

☐ No previous mental health treatment. (Must reside in the Sunnybrook Health Sciences Centre catchment area)

☐ Other (explain): _____

_____

_____

****Please fax to Denise Hayes @ 416-480-6818****

**Family Psychiatric History**

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