Mackenzie Health

Mackenzie Richmond Hill Hospital
10 Trench Street, Richmond Hill ON L4C 4Z3
905-883-1212

Cortellucci Vaughan Hospital
3200 Major Mackenzie Drive West, Vaughan ON L6A 4Z3
905-417-2000

Shaw Clinic Child and Family Services
Mental Health Program
(Providing Mental Health Services for ages 6-18 years)
Referral Form for Psychiatric Services

***Patient must consent to this referral if they have capacity to do so.**

Telephone: 905-883-2137 Fax: 905-883-2144

The child and family clinic is NOT able to accept referrals for assessments/treatments where concerns are related principally to:

- Legal issues
- If parents are actively in court regarding custody
- Anger management
- Behavioural disorders
- Eating disorders
- Primary substance abuse

****For patients requiring psychiatric consultation, the Shaw Clinic will be offering a one-time consultation and providing the referral source with detailed recommendations. To improve access to services, at this time psychiatrists will not be able to offer ongoing psychiatric follow up.**

Referring doctor: _____

Address: _____

Phone Number: _____ Fax Number: _____ Billing Number: _____

_____ _____
Physician Signature Date (dd/mm/yyyy)

Patient Information:

Date of Referral: _____ (dd/mm/yyyy)

Patient Name: _____ Date of Birth: _____
Last Name First Name dd/mm/yyyy

Address: _____ OHIP#: _____

Legal Guardian Name(s): _____

Please include all information where patient/legal guardian can be contacted:

Email Address of primary contact for referral (required) _____
***Please initial to provide confirmation that the patient has agreed to receive program information at this email address. Personal health information will not be shared. _____ Please ensure your patient regularly checks their "Junk" box, as emails may be filtered to "Junk".**
Initials

Home Telephone: _____

Legal Guardian's Cell Phone: _____
(If patient is incapable or agree to provide)

Patient's Cell Phone: _____

***Patient will not be contacted for their referral unless you acknowledge that a voicemail can be left at the above numbers by initialing here: _____**
Initials

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Custodial status

☐ No Applicable ☐ Joint Custody ☐ One Parent Has Sole Custody, Name: _____
☐ No Formal Custody ☐ Other: _____

Reason for Referral: (please provide details)

_____

_____

_____

☐ Has ADHD Diagnosis but requires an ADHD medication consult

Is there a current mental health diagnosis? ☐ Yes ☐ No

_____

_____

Please check any of the following mental health issues of concern to you:

☐ Significant anxiety or fears
☐ Decreased academic performance
☐ Depressed mood
☐ Suicidal thoughts, recurrent thoughts about death
☐ Impaired school attendance
☐ Decreased interest in or avoidance of activities
☐ Sleep changes
☐ Change in appetite
☐ Somatic complaints
☐ Social withdrawal
☐ Decreased selfcare
☐ Hallucinations (hear, see, feel, taste, smell things)
☐ Delusions (bizarre thoughts)
☐ Flight of ideas/racing thoughts
☐ Suspected alcohol/drug abuse
☐ Developmental disability

RISKS:	**Please explain:**		
Threat to self	☐ No	☐ Yes	When:
Threat to others	☐ No	☐ Yes	When:
Suicidal Ideation / Plan / Intent	☐ No	☐ Yes	When/Described:
Violent behaviour	☐ No	☐ Yes	When:

Please list any current medications (Medication/Dose/Duration)

_____

_____

_____

Allergies: _____

Other relevant health problems: _____

_____

Please forward recent investigations: (e.g., Blood work, EKG, Psychological Reports)

Completed By:

Name: _____ Signature: _____ Date: _____
dd/mm/yyyy