SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9

Child & Adolescent Mental Health

Health Record #: _____ Complete or place barcoded patient label here

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

DOB: dd / mm / yy Age: _____ ❑ Female ❑ Male

OHIP #: _____ Version Code: _____

Account #: _____ Date of Admission: dd / mm / yy

Out-Patient Program Psychiatric Consultation Request

This consultation request is for physicians' seeking diagnostic clarification for children and youth ages 6 – 18, and/or treatment recommendations.

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 schedule and appointment for the patient with one of our Psychiatrists. The Psychiatrist will determine if the patient is appropriate for either program.

Please indicate your preference for psychiatric consultation:

❑ I prefer for my patient to be booked for the next available psychiatric consultation.

OR

❑ I prefer for my patient to be booked for a psychiatric consultation with: *(please check preferred Psychiatrist)*

- ❑ Dr. Adam Enchin
- ❑ Dr. Diana Grigoreva
- ❑ Dr. Suri Naidoo
- ❑ Dr. Debbie Leung

Please attach any relevant documents, e.g. psychological/school assessments and fax to: (905) 830-5977.

Patient Name: *(print first, last)*		
Address:		
Date of Birth: dd / mm / yy	**Health Card Number:**	**Version Code:**

Caregiver 1 ❑ Custodial	**Caregiver 2** ❑ Custodial
Name: *(print first, last)*	**Name:** *(print first, last)*
Relationship:	**Relationship:**
Phone Number:	**Phone Number:**
Alternate Number:	**Alternate Number:**

REASON FOR CONSULTATION REQUEST:

Current medications, doses and frequency:

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

Referring Physician: *(print first, last)*	**OHIP Billing #:**
Signature:	**Date:** dd / mm / yy
Phone Number: ( )	**Fax Number:** ( )