596 Davis Drive
Newmarket, ON L3Y 2P9

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

Child & Adolescent Mental Health

Out-Patient Program Psychiatric Consultation Request

❑New Patient ❑Past Patient

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 and complete all required sections. You will receive a confirmation fax with the estimated wait time to share with your patient. Once they move up on the waitlist your patient will be contacted by Intake to book the consultation. The Psychiatrist will determine if the patient is appropriate for support.

CRITERIA:

→ Psychiatric consults available to patients living within the Central LHIN

→ Under 16 years old - informed consent required from both parents

Our clinic is not able to accept referrals where concerns are primarily related to :

→ Legal issues

→ Parents who are actively in court for custody

→ Primary substance abuse

→ Primary Eating disorders

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

Patient Name: *(print first, last)*		*Age:*
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:**
Email:	*Email:*

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:** ( )

❑All sections complete -By ticking this box you are confirming all sections are completed to avoid delays.

S-OUTPPPCR

SL1314HIS _15(10/22)"Child Adolescent Mental Health"Review (10/25)