SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9

Tel: (905) 895-4521, ext. 2215
Fax: (905) 830-5977

Physician Referral

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

Adolescent Medicine Clinic

Please email referral to adolescentmedicineclinic@southlake.ca

Patient Name: *(print first, last)*	Date: dd / mm / yy
Date of Birth: dd / mm / yy	Patient Phone Number:
Patient Parent/Guardian Name: *(print first, last)*	Patient Parent/Guardian Phone Number:
Family Physician/NP Name:	Telephone Number:
Family Physician/NP Address:	Fax Number:

Reason for referral

❑ Minor mental health (anxiety, depression) ❑ Coping with chronic illness ❑ Transition of care to adult healthcare

❑ Other _____

Treatment Started: _____

_____

Inclusion Criteria:

- Youth aged 12-18 years
- Developmentally able to engage with an adolescent-led approach to their care
- Issues related to general and minor mental health (anxiety, depression), coping with chronic illness, supporting the transition of care to adult healthcare
- Within hospital's catchment area policy

Exclusion Criteria:

- If there are concerns for an eating disorder, patients should be referred to the Eating Disorder Program at Southlake.
- If there are concerns for active primary psychiatric illness outside of minor mental health conditions (e.g. OCD, psychosis, schizophrenia, etc.) or acute safety concerns regarding active suicidal ideation, patients should be referred to Psychiatry services or the Emergency Department, as appropriate.
- If there are isolated behavioural or academic concerns, please refer to other appropriate services (e.g. General Pediatrics, Psychiatry, Developmental Pediatrics).
- Care for transgender and gender diverse youth is best delivered through an interdisciplinary clinic and as such, please consider referring patients to the Transgender Youth Clinic at SickKids for primary concerns related to the medical care and support for transgender and gender diverse youth.
- For primary alcohol and substance use concerns, please consider referring patients to multidisciplinary treatment teams, such as the Substance Use Program at SickKids, the Youth Addiction and Concurrent Disorders Service at CAMH, or other appropriate providers (e.g. Addictions Medicine).

By signing this form, I confirm that the patient is aware of this referral

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

THIS SECTION IS FOR ADOLESCENT MEDICINE CLINIC STAFF ONLY

REFERRAL: ❑ **ACCEPTED** ❑ **REJECTED**	Appointment Date: dd / mm / yy
Reason if rejected:	

Staff Name: *(print first, last)*	Staff Signature:	Date: dd / mm / yy