RVH
Royal Victoria Regional Health Centre

Child and Youth Mental Health Services Community Physician Referral Form

Form to be faxed with cover sheet to: (705)-719-4932

Referral Source:

☐ Pediatrician: Name: ____ Contact Number: (   )-_____-________

☐ Primary Care Provider: Name: ________________________________ Contact Number: (   )-_____-________

☐ Community Based Psychiatrist: Name: __________________________ Contact Number: (   )-_____-________

Client's Information

Full Legal Name:		
Preferred Name:		DOB:
Current address:		
City:	Province:	Postal Code:
Gender:	Phone:	Cellular:
Primary Care Provider:	Last Physical Exam:	
Health Card Number:		
School:	Grade:	Phone Number:

Parent/Guardian Information:

Legal Guardian Name:		Relationship
Current address:		
City	Province:	Postal Code:
Phone:	Child Resides with:	Relationship:

Current Agency Involvement:

☐ New Path	☐ CAS
☐ Kinark	☐ Family Connections
☐ HANDS	
☐ Other:	

Referral Information:

Patient's Current Diagnosis: ☐ None

Patient's Current Medications (including dose): ☐ None

Criteria for Acute Referral: Associated with mental illness

☐ Non-life threatening situation, with extreme emotional disturbance or behavioral distress.

☐ Considering or talking about harm to self or others

☐ Disoriented or out of touch with reality, compromised ability to function

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Reason for Referral:	
☐ Assessment/Diagnostic Clarification	☐ Crisis Assessment and Resource (If not completed in the Emergency Department)
☐ Medication Review	
What is the reason for this referral: Please Specify:	

What are the CONCERNS? (Please check all that apply):

- ☐ Anger/Oppositional Behaviour
- ☐ Anxiety
- ☐ Behaviour/Dysregulation
- ☐ Depression/Mood
- ☐ Developmental Delay
- ☐ Hallucinations/Delusions
- ☐ Hyperactivity
- ☐ Inattention
- ☐ Learning Difficulties
- ☐ Obsession/Compulsions
- ☐ Peer Relationship Difficulties
- ☐ School Difficulties
- ☐ Sleep Problems
- ☐ Substance Use
- ☐ Other (Please describe)

PROVIDE DETAILS ON SEVERITY OF THE PSYCHIATRIC CONCERNS AND THE EFFECT ON THE PATIENTS FUNCTIONING (attach copies of reports):

DEVELOPMENTAL CONCERNS OR KNOWN LEARNING CHALLENGES (attach copies of reports):

CONSENT

I ________________________________ **and** ________________________________

(Child/Youth Printed Name) ***(Legal Guardian Printed Name)***

Give consent for RVH Child and Adolescent Mental Health Outpatient Program employees to receive and share information related to the mental health assessment and treatment needs of:

________________________________ **with** ________________________________

(Child/Youth Printed Name) ***(Printed Name of Person or Hospital making referral)***

Signature of Child/Youth: ________________________ **Date:** ______________

Signature of Legal Guardian: ________________________ **Date:** ______________

Signature of Witness: ________________________ **Date:** ______________

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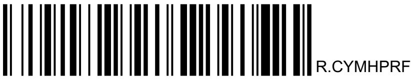

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