PEDIATRICS [6-12] REFERRAL FORM

Thrive Together
MENTAL WELLNESS CENTRES
Phone: 343-882-6766
Fax: 343-882-6768
ThriveTogether.ca

After completing, please fax to **343-882-6768**

Date of referral:

_____/_____/_____
YYYY MM DD

PATIENT CONTACT INFORMATION

_____
FIRST NAME

_____
LAST NAME

DOB _____/_____/_____
YYYY MM DD

_____
CELL PHONE

_____
ALTERNATE PHONE

_____
CELL PHONE

_____
ADDRESS

_____ _____
CITY POSTAL CODE

_____
EMAIL

_____
HEALTH CARD NO.

_____
VERSION CODE

PATIENT HISTORY

Are there current court/medical legal and/or custody matters? (Please provide details if applicable) ☐ YES ☐ NO

Previous Diagnosis ☐ YES ☐ NO

If YES, identify diagnosis: _____

_____

_____

MEDICATION AND DOSAGE (CURRENT)

MEDICATION	DOSAGE	DATE

Psychiatric/Medical History: _____

_____

_____

_____

_____

_____

_____

(please attach all relevant documents, assessment reports, and labs)

Current Vitals

Resting Blood Pressure: _____

Resting Heart Rate: _____

Height (cm): _____

Weight (kg): _____

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KINGSTON / OTTAWA
ThriveTogether.ca

REASON FOR REFERRAL (PLEASE INDICATE ALL THAT APPLY)

- ☐ Attention Deficit / Hyperactivity Disorders (ADD/ADHD)
- ☐ Depression
- ☐ Anxiety
- ☐ Learning
- ☐ Behauviour
- ☐ ODD
- ☐ Level 1 Autism
- ☐ Other: _____

☐ What specific issue or question would you like addressed by our team?

_____

_____

_____

_____

_____

_____

SERVICES REQUESTED (CHECK ALL THAT APPLY)

OHIP Funded Services:

- ☐ Child Mental Health Consult for Diagnosis and Treatment Recommendations
- ☐ Medication Consult for Attention Deficit/Hyperactivity Disorder (Prior Psychoeducational Assessment has been completed)
- ☐ Virtual Group Psychotherapy
- ☐ Emotion Focused skills training for Parents

Private Pay Services:

Might be covered by some private insurance plans

- ☐ Psychoeducational/ Learning Disabilities Assessment
- ☐ Ongoing Psychiatric Medication Management with Nurse Practitioner
- ☐ Psychodiagnostic Assessments with a Psychologist
- ☐ Autism Assessment
- ☐ ADHD & Executive Functioning Coaching
- ☐ Leadership and Career Coaching
- ☐ Individual, Couples or Family-Based Psychotherapy
- ☐ Occupational Therapy

_____
REFERRING PHYSICIAN/NURSE PRACTITIONER

_____
BILLING NO.

_____
PHONE

_____
FAX

_____
ADDRESS

_____

_____
EMAIL

I acknowledge that I am actively involved in the care of this patient and can act on the recommendations made by the clinicians from the Thrive Together clinic. Psychiatry recommendations will include a Medication Plan, where appropriate, specifying a medication recommendation and outlining a titration schedule. If there are questions about the Medication Plan or the patient's response to treatment at any time, I understand that I may consult with clinic physicians involved in the Medication Plan via e-consultation or telephone call. I also acknowledge that the Thrive Together clinic provides consultative care, with time limited follow up when indicated, and does not assume on-going care of this patient.

X _____
SIGNATURE

_____/_____/_____
DATE