JOSEPH BRANT HOSPITAL

Mental Health Services
Child and Adolescent Psychiatric Clinic
Telephone: (905) 631-0694 Fax: (905) 631-5804

Referral Date:_____ Referral Source:_____

Referring Physician's Billing #:_____

Physician's Telephone #:_____

Patient's Name:_____ Home Telephone #:_____

Address/City/Town:_____ Postal Code:_____

Date of Birth:_____ Age:_____

Next of Kin:_____ Telephone #:_____

Hospital Unit ID # (if known):_____ OHIP # & Version Code:_____

Family Physician:_____ Office Telephone #:_____Office Fax #:_____

School & Telephone Number:_____ Access to EAP: ☐Yes ☐ No

Reason for Referral:

☐ Behaviour Disorders of Childhood and Adolescence ☐ Mood Disorder
☐ Anxiety Disorder ☐ Adjustment Reaction ☐ Substance Abuse
☐ Psychosis ☐ Eating Disorder ☐ Developmental Delay
☐ Other

Current Symptoms & Stressors: _____

_____

_____

_____

Current Counselling & Medications:_____

_____

_____

Past Psychiatric Treatments/Hospitalizations:_____

_____

_____

Present Medical Illness & List of Medications:_____

_____

_____

Signature of Referring Physician:_____

- Please attach copies of any available reports.
- This Clinic is not able to provide any correspondence for court purposes.
- Please ensure all referrals are aware they must attend their scheduled appointments, if unable to attend we require 48-hour notification. Failure to comply with this and/or not attending the scheduled appointment without any notification may result in this referral being closed.