Family and Youth Clinic
1 Hospital Drive, Peterborough, ON K9J 7C6
t: 705-876-5114 | f: 705-876-5040

PATIENT LABEL

Referral Form

1. Client/Patient Information

Name:	DOB (DD/MM/YYYY):	☐ Male ☐ Female ☐ Other
Address:	Phone #:	Secondary phone #:
Health card:	Primary physician:	
Does the client/patient consent to referral? ☐ Yes ☐ No		Can we leave messages? ☐ Yes ☐ No

2. Next of Kin/Guardian Contact Information

Name:	Relationship to client:	Contact:
Name:	Relationship to client:	Contact:

3. Referral Source

Name:	PLACE REFERRAL SOURCE STAMP HERE
Telephone:	
Billing #:	
Fax:	
☐ I have attached all prior assessment/treatment/discharge summary notes and past medication history	

4. Psychiatric History

Previous diagnoses:
Current service providers (mental health, pediatric):
Past service providers:
Referred to other services: ☐ Yes ☐ No If yes, where:
Current medication:
Past medication:
Family mental health history:

5. Referral Request *(please check off)*

☐ Psychiatric Consultation* (specify): ☐ Medication consult ☐ Diagnostic clarification ☐ Treatment recommendations
☐ Therapy (treatment may be redirected to alternative treatment provider based on focus of concern)
☐ Urgent Care Clinic
☐ Eating Disorders (MUST complete section 9 for referral to be considered)

**Note that psychiatric consultations are one time only at the discretion of the psychiatrist*

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6. Reason(s) for Referral *(please check off all that apply)*

☐ Depressed Mood	☐ Mania	☐ Anxiety	☐ Obsessive compulsive and related disorders
☐ Trauma symptoms	☐ Suicidal ideation/self-Harm	☐ Disordered eating	☐ Emotion Dysregulation
☐ Family discord*			

**Note that this includes family dysfunction that impacts the mental health of the child. We do not see families who are in the midst of separation, divorce proceedings, and/or involved with family court at the time of referral*

7. Priority issues *(please check all that apply so we can prioritize your referral)*

☐ Some school avoidance or decrease in performance/engagement	☐ Missing more than 50% of school in a week
☐ Passive suicidal ideation (e.g., thoughts only)	☐ Active suicidal ideation (e.g., has a plan)
☐ Difficulties falling or staying asleep	☐ Day/night sleep reversal
☐ Episodic low mood or emotion dysregulation	☐ Persistent low mood majority of the week
☐ Mild/moderate anxiety symptoms (e.g., somatization, worries)	☐ Daily panic attacks
☐ Social isolation (not leaving house or socializing)	☐ Decreased need for sleep and increased energy
☐ Occasional self-harm	☐ Self-harm multiple times per week

8. Additional Areas of Concern *(please check, note that these are not primary reasons for a referral to our program)*

☐ Substance use	☐ Oppositional or explosive behaviour
☐ Developmental Issues	☐ ADHD
☐ Learning issues	☐ Autism spectrum disorder
☐ Intellectual disability/dual diagnosis	☐ Current caregiver custody or access concerns
☐ Current child protection concerns	☐ Gender dysphoria

9. Eating Disorder Symptomatology *(must be completed to prioritize treatment, please check all that apply)*

Current weight: _____ Current height: _____ Symptom onset? _____

☐ Existing eating disorder diagnosis (specify: _____)		☐ Food restriction	☐ Bingeing	☐ Purging
☐ Over exercising	☐ Laxative/Diuretic use	☐ Body Image Concerns	☐ Picky eating	
☐ Failure to gain weight	☐ Weight Loss (how much? _____)	☐ Weight Gain (how much? _____)		
☐ Amenorrhea	☐ Lanugo	☐ Abnormal Bloodwork	☐ Cold Intolerance	☐ Dizziness
☐ Abnormal Vital Signs/ECG	☐ Other: _____			

10. Comments