SickKids®
THE HOSPITAL FOR SICK CHILDREN

LAST NAME (FIRST)

DATE OF BIRTH YYYY - MM - DD SEX MRN

ADDRESS

IMPRINT OR ENTER DETAILS BY HAND

TeleLink Mental Health Program

TeleLink referral form

Agency #:_____ MRN:_____

Date (YYYY-MM-DD):_____ **Agency/Hospital:**_____ **Location:** _____

☐First Consultation ☐Follow Up

☐Professional-to-professional Consultation ☐Re-Assessment (If the date of original consultation is 1 year or more prior to this request)

Site Telephone Number: _____ Fax: _____ Case Manager: _____

Dates Not Available: _____

Family Doctor or Pediatrician:_____ Telephone Number:_____

Address:_____ City:_____ Postal Code:_____

Institution/Hospital _____ Address (If different):_____

City:_____ Postal Code:_____ Physician Billing Number: _____

MRP: ☐Yes ☐No If No, Please List _____

CLIENT INFORMATION

Patient's Name:_____ ☐Male ☐Female DOB:_____

Address:_____ City:_____ Postal Code:_____

Health Card #:_____ Version:_____ Exp.: _____

In Patient: ☐Yes ☐No If Yes, please state reason: _____

☐Crisis ☐Elective Admission Date (YYYY-MM-DD):_____ Expected Discharge Date (YYYY-MM-DD):_____

Guardians Name(s):_____ _____

Guardian Contact #: Day:_____ Evening:_____

Is legal guardians address the same as clients? ☐Yes ☐No If No please complete address section

Address:_____ City:_____ PC:_____

Legal Status: ☐Temporary Care Agreement ☐Temporary Care and Custody Order ☐Supervision Order
☐Society Wardship Order ☐Crown Wardship Order ☐Child protection order for custody (s. 65.2)
☐Customary Care Agreement

Residence Information

Resides with: ☐Bio-Mother ☐Bio-Father ☐Step-Mother ☐Step-Father ☐Same Sex Parents
☐Adoptive Mother ☐Adoptive Father ☐Extended Family ☐Independent Living ☐Other (please explain):

Please list complete names of individuals the client resides with and how they are related (i.e. sister, brother, step-father):

Resides where: (if other than family home)

☐Foster Home ☐Group Home (☐Short-Term ☐Long-Term) ☐Detention Centre ☐Secure Setting ☐Open

Custody Setting: ☐Custody/Detention Centre Treatment Program: ☐Yes ☐No Other:_____

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School Grade:_____ ☐Regular Class ☐Special Education ☐Day Treatment ☐Section 23 ☐Not Attending
Language Spoken by Client: ☐English ☐French Other:_____ Is an interpreter required? ☐Yes ☐No
Language Spoken by Parent(s): ☐English ☐French Other:_____
☐Aboriginal ☐First Nations ☐Metis ☐Inuit ☐On Reserve ☐Off Reserve
Armed Forces (Parents) ☐Yes ☐No
Currently before the courts ☐Yes ☐No ☐Sentenced/YJ
Explanation:_____

Reason for Referral: ☐Full Consultation re: ☐Diagnosis ☐Medication ☐Management:
Questions to be answered from this consultation (please be specific and attach additional information if needed):

MAJOR CONCERNS (Check those that apply)

☐Developmental Delay ☐FAE/FAS ☐Socialization Problems
☐School Problems: ☐Academic ☐Behavioral ☐Truancy ☐Other:_____
☐ADHD: ☐Inattentive ☐Impulsive ☐Hyperactive
☐Oppositional Defiant
☐Aggressive Behavior: ☐Verbal ☐Physical ☐Other:_____
☐Antisocial Behavior: ☐Substance Abuse ☐Alcohol ☐Drug ☐Firesetting ☐Other:_____
☐Conflict with the law Please specify:_____
☐Sexual Acting Out: ☐Current ☐Past Please Specify:_____
☐Mood Problems: ☐Depression ☐Mood Swings ☐Elevated Mood
☐Suicidal Behaviors: ☐Current ☐Past Please Specify:_____
☐Self-Harm: Type: Please Specify:_____
☐Anxiety ☐Obsessions ☐Compulsions ☐Worry ☐Avoidant Behavior
☐Somatization ☐Sleep Problems
☐Eating Disorder: Please explain_____
☐Family Conflict: ☐Separation from Parents/Family ☐Grief ☐Other:_____
☐Strange, Bizarre Behavior: ☐Hallucinations ☐Delusions
☐Witnessed Traumatic Events: ☐Physical ☐Emotional ☐Sexual
☐Experienced Trauma: ☐Physical ☐Emotional ☐Sexual

Parent(s)/Guardian(s) Concerns (attach additional information if needed):

Medical Problems:_____ Allergies:_____
Family History of Mental Illness (please specify and attach additional information if needed):

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Interventions: ☐None Currently ☐No previous Agency involvement

Counselling: ☐Individual ☐Family ☐Parent ☐Group ☐Other: _____

1. Involved in Specialized Program: _____

2. Had Previous Mental Health Consultation e.g. Psychologist, TAPP-(C), etc., (Not Telepsychiatry)

☐No ☐Yes Date (YYYY-MM-DD): _____ By Whom: _____

3. Are there any mental health assessments/interventions pending? _____

4. Is this child/youth currently involved with any other Mental Health Agency or Psychiatrist?

5. Current Medications

☐Stimulant (e.g. Ritalin) Name and Dosage: _____

☐SSRI or other Anti-Depressant Name and Dosage: _____

☐Mood Stabilizer Name and Dosage: _____

☐Anti-Psychotic Name and Dosage: _____

☐Anti-Anxiety (Benzodiazepines) Name and Dosage: _____

☐Other meds (e.g. Insulin) Name and Dosage: _____

Information that is mandatory for referral to proceed

☐Consent form ☐Case Summary/Assessment

Information provided for consultation (if available)

☐Admission History ☐Police Synopsis ☐Discharge Summary

☐Fire setting Assessment (if applicable) ☐BCFPI (if applicable)

☐CAFAS (if applicable) ☐Risk/Needs Assessment (if applicable)

Reports: ☐Education Assessment ☐Drug & Alcohol Assessment ☐Psychological Assessment

☐Speech & Language Assessment ☐Fire setting Assessment ☐School ☐Relevant Medical Information ☐Social History

☐Previous Psychiatric Consultations or other Consultations ☐Service Plan or Case Notes

☐Youth Justice Court Documents (please specify) ☐Other Behavioral Checklists: Please list