Royal Victoria Regional Health Centre

Simcoe Muskoka Regional CYMH Acute Service Referral Form

Sending Hospital Attach Patient Label

Form to be faxed to: (705) 719-4932		
Preferred Name:	Phone #:	Cell #:
Primary Care Provider:		
School:	Phone #:	Grade:

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	☐ Simcoe Muskoka Family Connexions (CAS)
☐ HANDS	☐ Other:

Referral Source:

☐ Emergency Department – Physician
Billing Number:_____
Name: (print) _____
Signature:_____

Referral Information:

Reason for referral & Patient's Current Diagnosis: (include severity of the psychiatric concerns and any development & learning challenges)

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

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

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

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

Reason for Referral:

☐ Assessment/Diagnostic Clarification	☐ Medication Review
☐ Crisis Assessment and Resource (if not completed in Emergency Department)	