

## Simcoe Muskoka Regional CYMH Acute Service Referral Form

Sending Hospital Attach Patient Label

Form to be faxed to: (705) 719-4932 Preferred Name:						
Primary Care Provider:   School:   Phone #:   Grade:		19-4932	DI "		0 " "	
School:			Phone #:		Cell #:	
Relationship						
Legal Guardian Name:   Relationship  Current address:   Province:   Postal Code:   Phone #:   Child Resides with:   Relationship:    Current Agency Involvement:     CAS			Phone #:		Grade:	
Current address:  City   Province:   Postal Code:   Postal Code:   Phone #:   Child Resides with:   Relationship:   Current Agency Involvement:   CAS   Child Resides with:   CAS		on:		Deletionalis		
City   Province:   Postal Code:   Phone #:   Child Resides with:   Relationship:    Current Agency Involvement:   CAS   Simcoe Muskoka Family Connexions (CAS)    HANDS   Other:   Referral Source:   Emergency Department – Physician   Billing Number:   Signature:   Signature:   Signature:   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   See attached List    What are the CONCERNS? (Please check all that apply):   School Difficulties   See attached List    What are the Concerns and any development & learning challenges   Peer Relationship Difficulties   See attached List    What are the Concerns and any development & learning challenges   Peer Relationship Difficulties   School Difficulties   School Difficulties   Substance Use    Developmental Delay   Depression/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				Relationship		
Phone #: Child Resides with: Relationship:  Current Agency Involvement:  New Path		<u> </u>				
Current Agency Involvement:	•					
New Path	**			Relationship:		
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HANDS  Referral Source:  □ Emergency Department – Physician Billing Number: □ Signature: □ Signature: □ Signature: □ Signature: □ Reason for referral & Patient's Current Diagnosis: (include severity of the psychiatric concerns and any development & learning challenges)  What are the CONCERNS? (Please check all that apply): □ Anger/Oppositional Behaviour □ Hallucinations/Delusions □ Peer Relationship Difficulties □ Anxiety □ Hyperactivity □ School Difficulties □ Anxiety □ 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						
Referral Source:    Emergency Department - Physician   Signature:   Signature:   Patient's Current Medications (including dose):   Patient's Current Medications (including dose):   None   See attached List						
Emergency Department – Physician   Billing Number:			□ Other:			
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□ 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	psychiatric concerns and any	development & learning	g challenges)	(including d ☐ None	ose):	
Anxiety				□ Peerl	Relationship 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	•				· · · · · · · · · · · · · · · · · · ·	
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