Referral Criteria – Psychopharmacology Services

Ambulatory Care

The Psychopharmacology Clinic is a service for clients whose complex medical and developmental differences require the need for medication management as a part of their overall treatment plan.

This clinic is offered at Holland Bloorview Kids Rehabilitation Hospital. We use a team approach to deliver coordinated services for children and families.

This clinic serves clients with Autism Spectrum Disorders and other complex medical and/or developmental disorders including epilepsy.

In order to be eligible for this service, the client must meet **all** the following criteria:

- Live in the province of Ontario
- Referral is made by a Physician or Nurse Practitioner
- Client is under the age of 17 (at the time of referral)
- Referral is accepted upon review of medication trial(s) by Psychopharmacology Clinic Intake Team
- **Psychopharmacology – Supplemental Referral Form** must be completed before referral will be accepted

Please note that *the client/family must be aware of the referral.

Holland Bloorview Kids Rehabilitation Hospital
150 Kilgour Road, Toronto ON Canada M4G 1R8
T 416 425 6220 **T** 800 363 2440 **F** 416 425 6591
www.hollandbloorview.ca

Holland Bloorview
Kids Rehabilitation Hospital

Appointment Services: 150 Kilgour Rd. Toronto, ON, M4G 1R8
Tel: (416) 424-3804 Fax: (416) 422-7036

PHYSICIAN / NURSE PRACTITIONER REFERRAL FORM – OUTPATIENT SERVICES

Please complete all sections of this form as incomplete forms will result in processing delays. **NOTE: This information will be shared with Holland Bloorview staff as required.**

Family is aware of this referral: Yes ☐ (must be checked) Referral Date: ________________(dd/mm/yy)

CLIENT INFORMATION:

Client Name: ____
Last Name First Name Middle Initial

Date of Birth: ______________________ ☐ Male ☐ Female
Day / Month / Year

Is an interpreter required? ☐ Yes ☐ No Language spoken:____________________________

Client Address: ______________________City:______________________

Province: ________________ Postal Code: ________________ Tel.:______________________

Health Card Number: ______________________ Version Code: ______________________

☐ Interim Federal Health Program (IFHP) ☐ Health Card In Process

Client lives with: ☐ Both parents ☐ Father ☐ Mother ☐ Guardian ☐ Independent ☐ Group Home ☐ Other:

PARENT(S) OR GUARDIAN(S): (if different from client address)

Parent/Guardian: ____

Address:____

Email:____

Tel. (home): ________________Tel. (work):________________Tel. (cell): ________________

Parent/Guardian: ____

Address:____

Email:____

Tel. (home): ________________Tel. (work):________________Tel. (cell): ________________

AGENCIES/PROFESSIONALS CURRENTLY INVOLVED:

Agency (eg. Child Protection, Community)	Professional (eg. OT, SLT, Psychologist)
1.______________________	______________________
2.______________________	______________________
3.______________________	______________________

MEDICAL INFORMATION:

Primary Diagnosis:

___

Other Diagnoses:

___

Does this client require any special infectious disease precautions? ☐ **Yes** ☐ **No**

If yes, what for: ___

Medical History/Allergies:

___

___

Taking Medication: ☐ Yes ☐ No

Risks (i.e. frequent falls)

___

Reason for Referral/Concern/Goals:

___

___

Use check box for referral:

- ❑ Query Autism
- ❑ Acquired Brain Injury Rehabilitation
- ❑ Concussion Clinic
- ❑ Cleft Lip & Palate Speech Language Pathology
- ❑ Infant Development Services
- ❑ Neuromotor (e.g. cerebral palsy, global developmental delay, Retts)
- ❑ Psychopharmacology* (additional forms required)
- ❑ Neuromuscular (e.g. muscular dystrophy)
- ❑ Feeding* (additional forms required)
- ❑ Spina Bifida
- ❑ Spinal Cord Injury
- ❑ Augmentative & Alternative Communication (AAC)
  - ❑ Writing Aids
- ❑ Orthotics (including protective headwear)
- ❑ Prosthetics (including myoelectric & cosmetic)
- ❑ Clinical Seating

Dental Services:

- ❑ Cleft Lip & Palate (general anesthesia available for qualifying clients)
- ❑ Special Needs Dentistry (general anesthesia available for qualifying clients)

***Pre-assessment forms are required with the referral. Click the link below:**

- **Feeding services**
- **Psychopharmacology clinic**

REFERRING MD/NP/DDS Name: ___

OHIP Billing Number: ___

Hospital: ___

Telephone: ___ Fax: ___

Email: ___

Signature: ___

Please fax your completed Referral Form to Appointment Services: (416) 422-7036