

# 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.***

**PHYSICIAN / NURSE PRACTITIONER REFERRAL FORM – OUTPATIENT SERVICES**

Family is aware of this referral:  Yes  No (must be checked) Referral Date: \_\_\_\_\_ (dd/mm/yy)

<b>CLIENT INFORMATION:</b>		
Client Name: _____		
Last Name	First Name	Middle Initial
Chosen Name: _____ Preferred Pronoun: _____		
Date of Birth: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female _____		
Day / Month / Year		
Client Address: _____		
Apt/Unit #: _____ City: _____ Province: _____		
Postal Code: _____ Tel.: _____		
Is an interpreter required? <input type="checkbox"/> Yes <input type="checkbox"/> No Language spoken: _____		
If yes, would over-the-phone interpretation be possible for this client (i.e. is hearing/speaking an issue?) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Health Card Number: _____ Version Code: _____		
Interim Federal Health Program (IFHP) <input type="checkbox"/> Yes <input type="checkbox"/> No Health Card In Process <input type="checkbox"/> Self-Pay <input type="checkbox"/> 3 <sup>rd</sup> Party <input type="checkbox"/>		
Client lives with: <input type="checkbox"/> Both Parents <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Guardian <input type="checkbox"/> Independent <input type="checkbox"/> Group Home <input type="checkbox"/> Other _____		
Does the child have a sibling that receives/received services at Holland Bloorview? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are there custody or access arrangements that the health care team should be aware of? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are child welfare services involved with the child? E.g. CAS, JF&CS, CFS, etc.? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Preferred Contact</b>		
Name: _____ Relationship to Child: _____		
Address (if different from child): _____		
Email: _____		
Tel. (home): _____ Tel. (cell): _____ Tel. (work): _____		
<b>Secondary Contact</b>		
Name: _____ Relationship to Child: _____		
Address (if different from child): _____		
Email: _____		
Tel. (home): _____ Tel. (cell): _____ Tel. (work): _____		

**AGENCIES/PROFESSIONALS CURRENTLY INVOLVED:**

Agency (e.g., Child Protection, Community)

Professional (e.g., OT, SLP, Psychologist)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_



## MEDICAL INFORMATION:

Primary Diagnosis:

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Other Diagnoses:

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

If yes, what for: \_\_\_\_\_

Medical History/Allergies:

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Taking Medication:  Yes  No

Please include PRN medications and provide details related to frequency, dose, effectiveness/response, side effects, etc.)

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Other information/Risks (i.e. frequent falls)

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Reason for Referral/Concern/Goals:

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### Use check box for referral:

- Query Autism
    - Client does not already have a diagnosis of autism spectrum disorder (must be checked to be accepted)
    - Client has not been assessed for ASD in the past 12 months (must be checked to be accepted)
    - Description of child's current presentation and/or issues that led to this question (most recent relevant consult note must be attached to be accepted)
  - Spinal Cord Injury
  - Orthotics (including protective headwear)
  - Prosthetics (including myoelectric & cosmetic)
  - Clinical Seating
  - Communication & Writing Aids Services
    - Augmentative & Alternative Communication (AAC)
    - Writing Aids
  - Extensive Needs\* (additional forms required)
  - Motion Analysis Centre
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- Acquired Brain Injury Rehabilitation
- Baby CIMT
- Concussion Clinic\* (additional forms required)
- Cleft Lip & Palate Speech Language Pathology
- Family Centred Intervention Services for Children (0-5)
- Neuromotor (e.g. cerebral palsy, global developmental delay, Retts)
- Psychopharmacology\* (additional forms required)
- Neuromuscular (e.g. muscular dystrophy)
- Feeding\* (additional forms required)
- Spina Bifida

### Transitions, Recreation & Life skills:

- Employment & Volunteering
- Life Skills Coaching
- Post-Secondary Transition Service
- Therapeutic Recreation Services

### 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 here:

Feeding: <http://hollandbloorview.ca/programsandservices/programsservicesaz/feedingservices>

Psychopharmacology: <http://hollandbloorview.ca/programsandservices/ProgramsServicesAZ/Psychopharmacologyclinic>

Augmentative & Alternative Communication (AAC): <https://hollandbloorview.ca/services/programs-services/augmentative-and-alternative-communication>

Extensive Needs: <https://hollandbloorview.ca/services/programs-services/extensive-needs-service>

Special Needs Dentistry: <https://hollandbloorview.ca/services/programs-services/dental-services>

Concussion Service: <https://hollandbloorview.ca/services/programs-services/concussion-centre/concussion-services/clinical-services>

REFERRING MD/NP/DDS Name: \_\_\_\_\_

OHIP Billing Number: \_\_\_\_\_

Referring provider is not the client's Primary Care Provider

Hospital: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Signature: \_\_\_\_\_

\*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.**

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

