Tele-Mental Health Services,
provided by

LAST NAME	FIRST
MRN	VISIT NUMBER
DATE OF BIRTH YYYY-MM-DD	SEX
ADDRESS	

IMPRINT OR ENTER DETAILS BY HAND

Referral Form

Agency Client #: ____________ MRN: ____________ Date of Request: ____________
YYYY - MM - DD

Coordinating Agency: ☐ AFS ☐ Dilico ☐ HANDS ☐ SOAHAC ☐ Weechi-it-te-win ☐ Woodview

Referring Agency: ____________

Location: ____________ Telephone #: ____________

Fax # Report is to go to (1# per agency / location): ____________

Case Manager: ____________

Severity scale prior to service as per case manager: ☐ 1 ☐ 2 ☐ 3 ☐ 4

☐ 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)

Dates Not Available: ____________

____

Family Doctor or Paediatrician: ____________
Address: ____________ City: ____________ Postal Code: ____________
Telephone #: ____________ Fax #: ____________

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 Behavioural Checklists: Please list

Tele-Mental Health Services,
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ADDRESS	

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Referral Form

CLIENT INFORMATION

Patient's Name:______________________ ☐ Male ☐ Female DOB:__________ (YYYY - MM - DD)

Address:______________________ City:__________ Postal Code:_______

Health Card #:______________________ Version:__________ Exp.:__________ (YYYY - MM - DD)

Guardian Name(s):______________________

Guardian Contact #: Primary:__________ Secondary:__________

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

Address:______________________ City:__________ Postal Code:_______

Custodial Status: ☐ Intact ☐ Joint* ☐ Sole Custody* ☐ 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 ☐ Kinship Agreement

* Please provide legal documentation

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: __________

School Grade: _____ ☐ Regular Class ☐ Special Education ☐ Day Treatment ☐ Section 23 ☐ Not Attending

Language(s) spoken by client: ☐ English ☐ French Other:__________

Is an interpreter required? ☐ Yes ☐ No

Language(s) spoken by parent(s): ☐ English ☐ French Other:__________

☐ Aboriginal ☐ First Nations ☐ Metis ☐ Inuit ☐ On Reserve ☐ Off Reserve

Currently before the courts ☐ Yes ☐ No ☐ Sentenced / YJ

Explanation:______________________

Tele-Mental Health Services,
provided by

SickKids® CPRI CHILD & PARENT RESOURCE INSTITUTE

NUMBER

SEX

ADDRESS

IMPRINT OR ENTER DETAILS BY HAND

Referral Form

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):

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

Medical Problems and Allergies:

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

Tele-Mental Health Services, provided by

SickKids® CPRI CHILD & PARENT RESOURCE INSTITUTE CHEO

SURNAME	FIRST
MRN	VISIT NUMBER
DATE OF BIRTH YYYY-MM-DD	SEX
ADDRESS	

IMPRINT OR ENTER DETAILS BY HAND

Referral Form

MAJOR CONCERNS (Check those that apply)

☐ Developmental Delay ☐ FAE / FAS ☐ Socialization Problems

☐ School Problems: ☐ Academic ☐ Behavioural ☐ 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

Interventions: ☐ None Currently ☐ No previous Agency involvement

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

1. Involved in Specialized Program:____________
2. Had Previous Mental Health Assessments e.g. psychiatric, psychological, TAPP-(C), etc., (Not Telepsychiatry)

☐ No ☐ Yes Date:____________ By Whom:____________
YYYY - MM - DD

Tele-Mental Health Services,
provided by

CPRI
CHILD & PARENT
RESOURCE INSTITUTE

LAST NAME	FIRST
MRN	
DATE OF BIRTH YYYY/MM/DD	SEX
ADDRESS	

IMPRINT OR ENTER DETAILS BY HAND

Referral Form

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

____

4. Current Medications

☐ Stimulant — Name and Dosage:______
Name and Dosage:______
Name and Dosage:______

☐ SSRI or other Anti-Depressant — Name and Dosage:______
Name and Dosage:______
Name and Dosage:______

☐ Mood Stabilizer — Name and Dosage:______
Name and Dosage:______
Name and Dosage:______

☐ Anti-Psychotic — Name and Dosage:______
Name and Dosage:______
Name and Dosage:______

☐ Anti-Anxiety — Name and Dosage:______
Name and Dosage:______
Name and Dosage:______

☐ Other meds — Name and Dosage:______
Name and Dosage:______
Name and Dosage:______

Tele-Mental Health Services,
provided by

IMPRINT OR ENTER DETAILS BY HAND

Follow-up Form

Agency Client #: ____________ MRN: ____________ Date of Request: ____________ (YYYY - MM - DD)

Coordinating Agency: ☐ AFS ☐ Dilico ☐ HANDS ☐ SOAHAC ☐ Weechi-it-te-win ☐ Woodview

Referring Agency: ____________

Location: ____________ Telephone #: ____________

Fax # Report is to go to (1# per agency / location): ____________

Case Manager: ____________

☐ Second Opinion ☐ Follow-up Consultation

Client Name: ____________ DOB: ____________ (YYYY - MM - DD)

Health Card Number: ____________ Version Code: ________ Expiry Date: ____________ (YYYY - MM - DD)

Date of Last Consultation: ____________ (YYYY - MM - DD)

Name of Consultant: ____________

Reason for Request (please be specific): ____________

Dates Clinician is NOT available: ____________

Requested Timeframe: ____________

CENTRAL INTAKE USE ONLY
☐ Consent Valid (signed within the last year)

Tele-Mental Health Services,
provided by

SickKids | CPRI CHILD & PARENT RESOURCE INSTITUTE | CHEO

LAST NAME FIRST
MRN VISIT NUMBER
DATE OF BIRTH (YYYY-MM-DD) SEX
ADDRESS

IMPRINT OR ENTER DETAILS BY HAND

Consent to the Disclosure of Personal Health Information

Agency client #: ______________________ MRN: ________________

☐ Client
☐ Guardian / Substitute decision maker

I, ______________________________
Enter Name

authorize one of the Tele-Mental Health Service locations to disclose the personal health information of:

____
Enter Client Name

consisting of: **Tele-Mental Health Consultation Report,** ______________________________

To the following: ______________________________
Enter name of Physician, Mental Health Agency etc.

____
Enter name of Physician, Mental Health Agency etc.

☐ Client
☐ Guardian / Substitute decision maker

I, ______________________________
Enter Name

authorize the **Tele-Mental Health Coordinating Agency** & ______________________________
Name of Site, Physician, Mental Health Agency etc.

to disclose the personal health information of ______________________________
Enter Client Name

consisting of: ______________________________
Describe the personal health information to be disclosed

To one of the Tele-Mental Health Service locations.

Notice of Collection

Information collected through Tele-Mental Health Services will be entered into a data system used to process and schedule appointments, for quality improvement, for approved research studies that do not require information identifying the patient, and for other purposes permitted or required by law. This includes disclosure of personal health information to The Institute for Clinical Evaluative Sciences (ICES) as a prescribed entity for the purposes of section 45 of the Ontario's Personal Health Information Privacy Act. Information collected in this way will be pooled with other similar information and no one participating in this consultation will be individually or specifically identified.

☐ **I agree to be contacted to learn more about research opportunities I / my child may wish to participate in. I am aware that declining to participate in teaching and/or any research related activities will not have any impact on any services I / my child will receive through Tele-Mental Health Services.**

Print name	Signature	Date (YYYY - MM - DD)	Time

Print name	Signature	Date (YYYY - MM - DD)	Time

Tele-Mental Health Services,
provided by

IMPRINT OR ENTER DETAILS BY HAND

Consent to Release of Information for Program Consultation Purposes

Part one

Dear: ______________________________
Parent or Guardian

______________________________ ______________________________
Name of Client — Client's Date of Birth (YYYY-MM-DD)

Will be receiving service from the:

____
Name of Agency Program

To better support staff in this program, we may schedule consultations with other clinical consultants from the Tele-Mental Health Services. During these program consultations issues relating to your child may come up and we would like your written permission to discuss them with our consultant(s) in Tele-Mental Health Services. All information is treated confidentially and there will not be a written report about your child.

Part two if applicable ☐

We feel it is also important to let your family doctor or paediatrician know that we may be talking to a consultant about your child as part of the above mentioned agency program.

We would like to send a copy of this letter to your child's physician and ask that you sign this consent form in order for us to do this.

If you have any questions, please speak with your case manager.
Thank you for your cooperation.

Yours truly,

____
Per: D. Willis (Hub staff), Program Manager

Cc. ______________________________ ☐ If applicable
Attending physician

______________________________ ______________________________
Parent/Guardian signature — Date (YYYY-MM-DD)

Hub site use only

Copy to parent/guardian: ____________ Date (YYYY-MM-DD) copy to physician: ____________ Date (YYYY-MM-DD) copy to file: ____________ Date (YYYY-MM-DD)

Tele-Mental Health Services,
provided by

IMPRINT OR ENTER DETAILS BY HAND

Information about your Video Meeting

Why am I here today?

After discussions with you, your worker or doctor has decided to refer you for a video meeting with a child psychiatrist and/or other professional for extra help.

What is a child psychiatrist?

A child psychiatrist is a doctor that tries to help kids and their families by talking to them about their thoughts, worries, and behaviours.

How does a video meeting work?

A video meeting allows you to talk to someone in another location through two-way live television, connected by a private internet connection. This means that no one can listen in on your conversation.

How long will it last?

The meeting should last about 1 to 2 hours.

Who will be in the room with me?

Your worker or doctor will be in the room with you, to make sure that you are comfortable and that everyone is safe. Also your parent(s), guardian(s), and other people working with you may be in the room, at least for some of the time. The psychiatrist you will meet on TV may have medical students in the room with him/her.

What will happen during the meeting?

The psychiatrist may want to speak with everyone in the room. You will be asked many questions so that the psychiatrist can get to know you and your situation. At the end of the time, the psychiatrist will share his/her thoughts on what might help you. It is up to you, with your family, case worker, and doctor, how to use these suggestions. If any medications are suggested, they will be given to you by your own doctor.

What happens after the meeting?

The psychiatrist will prepare a report which will go to your worker and/or doctor. If you want the report to go to anybody else, then you and/or your parent(s) / guardian(s) will have to sign a form allowing that to happen. If anything comes up that makes the psychiatrist concerned about you harming yourself or somebody else, or that you are at risk of being harmed or abused, then the psychiatrist will work with your worker/doctor to make sure that everybody is safe.

Will I see the psychiatrist again?

You may see the psychiatrist this one time only and he/she will not be your ongoing doctor. We realize that sometimes it is not enough to meet with a psychiatrist just one time and if other meetings need to happen, they will be arranged through your worker or doctor.

What if I have other questions?

We hope that you will be comfortable talking with the psychiatrist in the video meeting. If you have any questions or worries about it, please let your worker, doctor, or psychiatrist know. If you have any ideas on how we can make this a better experience for you, we would like to know about those too.

Print name	Signature	Date (YYYY - MM - DD)	Time

*For referring agency record only

Tele-Mental Health Services,
provided by

LAST NAME FIRST

MRN HEALTH NUMBER

DATE OF BIRTH YYYY-MM-DD SEX

ADDRESS

IMPRINT OR ENTER DETAILS BY HAND

Consent to the Disclosure of Personal Health Information – Youth Justice

Agency client #:____________________ MRN:____________________

I, ____ ☐ Client ☐ Guardian / Substitute decision maker
Enter Name

authorize one of the Tele-Mental Health Service locations to disclose the personal health information of:

____
Enter Client Name

consisting of: **Tele-Mental Health Consultation Report,**____________________

To the following: ____
Enter name of Physician, Mental Health Agency etc.

____
Enter name of Physician, Mental Health Agency etc.

I, ____ ☐ Client ☐ Guardian / Substitute decision maker
Enter Name

authorize the **Tele-Mental Health Coordinating Agency** & ____________________
Name of Site, Physician, Mental Health Agency etc.

to disclose the personal health information of ____________________
Enter Client Name

consisting of: ____
Describe the personal health information to be disclosed

To one of the Tele-Mental Health Service locations.

Notice of Collection

Information collected through Tele-Mental Health Services will be entered into a data system used to process and schedule appointments, for quality improvement, for approved research studies that do not require information identifying the patient, and for other purposes permitted or required by law. This includes disclosure of personal health information to The Institute for Clinical Evaluative Sciences (ICES) as a prescribed entity for the purposes of section 45 of the Ontario's Personal Health Information Privacy Act. Information collected in this way will be pooled with other similar information and no one participating in this consultation will be individually or specifically identified.

☐ **I agree to be contacted to learn more about research opportunities I/my child may wish to participate in.**
I am aware that declining to participate in teaching and/or any research related activities will not have any impact on any services I/my child will receive through Tele-Mental Health Services.

CAUTION: THIS RECORD CONTAINS INFORMATION ABOUT A YOUNG PERSON WHICH IS SUBJECT TO THE YOUTH CRIMINAL JUSTICE ACT! Information about a young person as defined in the Youth Criminal Justice Act is subject to publication, use and access restrictions set out in the Act to protect the privacy of the young person. The penalty for violation may result in imprisonment for up to 2 years.

Print name	Signature	Date (YYYY-MM-DD)	Time

Tele-Mental Health Services,
provided by

LAST NAME (FIRST)
NAME AS PER HC
MRN VISIT NUMBER
DATE OF BIRTH SEX
YYYY-MM-DD
DOB AS PER HC
ADDRESS
CURRENT ADDRESS OR ADDRESS OF CAS IF IN FOSTER HOME
IMPRINT OR ENTER DETAILS BY HAND

Consent to the Disclosure of Personal Health Information

Agency client #: ____________ MRN: ____________

I, NAME OF THE GUARDIAN (or client if older than 12) ☑ Client ☑ Guardian / Substitute decision maker
Enter Name

authorize one of the Tele-Mental Health Service locations to disclose the personal health information of:

NAME OF THE CLIENT
Enter Client Name

consisting of: **Tele-Mental Health Consultation Report,** AND ANY RELEVANT INFORMATION

To the following: NAME(S) OF WHOMEVER SHOULD RECEIVE A COPY OF THE REPORT...
Enter name of Physician, Mental Health Agency etc.

Doctors, case workers, specialists etc.
Enter name of Physician, Mental Health Agency etc.

I, NAME OF THE GUARDIAN (or client of older than 12) ☑ Client ☑ Guardian / Substitute decision maker
Enter Name

authorize the **Tele-Mental Health Coordinating Agency** & NAME OF THE REFERRING PHYSICIAN
Name of Site, Physician, Mental Health Agency etc.

to disclose the personal health information of NAME OF THE CLIENT
Enter Client Name

consisting of: ALL MEDICAL HEALTH RECORDS AND REPORTS
Describe the personal health information to be disclosed

To one of the Tele-Mental Health Service locations.

Notice of Collection

Information collected through Tele-Mental Health Services will be entered into a data system used to process and schedule appointments, for quality improvement, for approved research studies that do not require information identifying the patient, and for other purposes permitted or required by law. This includes disclosure of personal health information to The Institute for Clinical Evaluative Sciences (ICES) as a prescribed entity for the purposes of section 45 of the Ontario's Personal Health Information Privacy Act. Information collected in this way will be pooled with other similar information and no one participating in this consultation will be individually or specifically identified.

☐ **I agree to be contacted to learn more about research opportunities I/my child may wish to participate in. I am aware that declining to participate in teaching and/or any research related activities will not have any impact on any services I/my child will receive through Tele-Mental Health Services.**

DON'T FORGET TO PRINT NAME, SIGN		DATE	TIME
Print name	Signature	Date (YYYY - MM - DD)	Time
DON'T FORGET TO PRINT NAME, SIGN		DATE	TIME
Print name	Signature	Date (YYYY - MM - DD)	Time

Severity Scale Ratings:

1	All Children, Youth and their families/caregivers
2	Children and youth at risk for or experiencing mental health problems affecting their functioning is some areas
3	Children and Youth who are experiencing significant mental health problems that affect functioning in some areas such as school/home/community
4	Children and Youth experiencing the most severe, complex, rare or persistent diagnosable mental illness that significantly impair functioning in most areas such as home/school and community

Hello Everyone, Above are the four categories provided by MCYS and below is further clarification as to how the rating scale works.

1- would be yes everyone
2 – kids at risk of experiencing a MH issue
3- kids who are **EXPERIENCING** a MH issue
4- kids who are **EXPERIENCING SIGNIFICANT** MH issues

The key words are highlighted.

We are just looking for their point of view on the front end. The doctor will also be doing the severity scale at the end so this will give us a more accurate look at what the severity is.

Remember – nobody is **wrong or right !**

Please feel free to contact me if in need of help.
Christine

Aboriginal Child & Youth Tele-Mental Health Service
Aboriginal Questionnaire

1. I would identify myself as: ☐ First Nation (Status) ☐ First Nation (Non-Status)
☐ Metis ☐Inuit ☐Other (please identify) ____________________

2. My Nation is: ☐Algonquin ☐Cayuga ☐Chippewa☐ Cree ☐Delaware ☐Inuit
☐Metis ☐Mississauga ☐Mohawk ☐Odawa ☐Ojibway ☐Onondaga ☐Oneida
☐Potawatomi☐Seneca ☐Tuscarora
☐Other (please identify):____________________
☐ Do Not Know ☐Prefer not to answer

3. My Band is ____________________

4. I identify spiritually as:
☐ Clan ____________________☐Do not know ☐ Prefer not to answer
☐ Colour(s) ____________________ ☐Do not know ☐ Prefer not to answer
☐ Spirit Name ____________________ ☐Do not know ☐ Prefer not to answer

5. Language spoken at home is: ____________________

6. Describing my family story:
Have any of your family members attended Residential School?
☐Yes ☐No ☐ Do not know ☐ Prefer not to answer
Was your family affected by the 60's Scoop?
☐ Yes ☐ No ☐ Do not know ☐ Prefer not to answer

7. Have you or any of your family participated in Traditional healing or taken Traditional medicines. Participated in Traditional sweats or ceremonies? Please explain.____________________
____
____

8. Do you have a cultural teacher or healer? If so what is their name?

____

9. How do you identify culturally? (Please circle)
Bi-Cultural Metis Non- Traditional Traditional

10. Are you interested in receiving health services that are specific to your Aboriginal culture? For example, would you like to use a Traditional Healer?
____

Miigwetch/Yaw^ko/Wellaylin/Wanishi/Thank you

Southwest Ontario
Aboriginal Health
Access Centre

CONSENT TO RELEASE OR TO OBTAIN INFORMATION

(Pursuant to the Personal Health Information Protection Act 2004 (PHIPA))

I,____

(Print your name and relationship if you are Parent/ Guardian/ or Substitute Decision Maker)

For____________________________, **Date of Birth** __________________

(Self/ or Name of person) (dd/mm/yyyy)

Address____________________________, and **Phone Number**______________

Do hereby give consent to____

(Name/Title/ Organization of Health Information Custodian)

TO RELEASE/OBTAIN THE FOLLOWING INFORMATION REGARDING: _________

____

TO/ FROM ____

(Name/ Title/ Organization)

This information will be used for the following purpose(s):______________________

____

I understand the purpose for disclosing this personal health information, and that I can refuse to sign this consent form or later withdraw my consent.

______________________________________ ____________________

(Signature of Client, Parent(s), Guardian(s), or Substitute Decision Maker) (Date: dd/mm/yyyy)

______________________________________ ____________________

(Witness Name, Signature, and Title) (Date dd/mm/yyyy

***Please note: A substitute decision-maker is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual.**

**Should there be any cost levied for this information please contact the Health Centre prior to making any photocopies.

<u>PLEASE NOTE</u>: This Authorization is valid for □ 6 months □ 12 months and pertains to the disclosure of information that is specific to services received on or before the date signed. It can be amended or withdrawn at any time by written notification to Southwest Ontario Aboriginal Health Access Centre. Note: if not designated above, the validation is good for 6 months only.