New Referring Agency ☐

Agency Name:	
Agency Address:	
Agency Phone:	
Agency Fax #:	
Tele-psychiatry Contact Person :	
Phone Number:	
Email address:	

New Referring Physician ☐

Physician Name:	
Physician Address:	
Physician Phone:	
Physician Fax #:	
Physician Billing Number:	
Tele-psychiatry Contact Person :	
Phone Number:	
Email address:	

Tele-Mental Health Services,
provided by

SickKids® CPRI Child and Parent Resource Institute CHEO

LAST NAME FIRST
M.R.# VISIT NUMBER
DATE OF BIRTH SEX
YYYY/MM/DD
ADDRESS

IMPRINT OR ENTER DETAILS BY HAND

Referral Form

Agency #:_____ MRN:_____

Date (YYYY-MM-DD):_____ **Agency/Hospital:**_____ **Location:** _____
☐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)
Site Telephone Number: _____ Fax: _____ Case Manager: _____
Dates Not Available: _____
Family Doctor or Pediatrician:_____ Telephone Number:_____
Address:_____ City:_____ Postal Code:_____
Institution/Hospital _____ Address (If different):_____
City:_____ Postal Code:_____ Physician Billing Number: _____
MRP: ☐Yes ☐No If No, Please List

CLIENT INFORMATION

Patient's Name:_____ ☐Male ☐Female DOB:_____
Address:_____ City:_____ Postal Code:_____
Health Card #:_____ Version:_____ Exp.: _____
In Patient: ☐Yes ☐No If Yes, please state reason: _____
☐Crisis ☐Elective Admission Date (YYYY-MM-DD):_____ Expected Discharge Date (YYYY-MM-DD):_____
Guardians Name(s):_____
Guardian Contact #: Day:_____ Evening:_____
Is legal guardians address the same as clients? ☐Yes ☐No If No please complete address section
Address:_____ City:_____ PC:_____

Legal Status: ☐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

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:

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Referral Form

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

Language Spoken by Client: ☐English ☐French Other: Is an interpreter required? ☐Yes ☐No

Language Spoken by Parent(s): ☐English ☐French Other:

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

Armed Forces (Parents) ☐Yes ☐No

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

Explanation:

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):

MAJOR CONCERNS (Check those that apply)

☐Developmental Delay ☐FAE/FAS ☐Socialization Problems

☐School Problems: ☐Academic ☐Behavioral ☐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 ☐PastPlease 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

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

Medical Problems:_____ Allergies:_____

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

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Referral Form

Interventions: ☐None Currently ☐No previous Agency involvement

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

1. Involved in Specialized Program: _____
2. Had Previous Mental Health Consultation e.g. Psychologist, TAPP-(C), etc., (Not Telepsychiatry)
   ☐No ☐Yes Date (YYYY-MM-DD): _____ By Whom: _____
3. Are there any mental health assessments/interventions pending? _____
4. Is this child/youth currently involved with any other Mental Health Agency or Psychiatrist?

5. Current Medications

☐Stimulant (e.g. Ritalin)	Name and Dosage: _____
☐SSRI or other Anti-Depressant	Name and Dosage: _____
☐Mood Stabilizer	Name and Dosage: _____
☐Anti-Psychotic	Name and Dosage: _____
☐Anti-Anxiety (Benzodiazepines)	Name and Dosage: _____
☐Other meds (e.g. Insulin)	Name and Dosage: _____

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 Behavioral Checklists: Please list

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IMPRINT OR ENTER DETAILS BY HAND

Consent to the Disclosure of Personal Health Information

Agency #:_____ MRN:_____

Section A

I, _____ ☐ Client ☐ Guardian
Enter Name

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

_____
Enter Client Name

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

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

_____
Enter name of Physician, Mental Health Agency etc.

Section B

I, _____ ☐ Client ☐ Guardian
Enter Name

authorize_____
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.

Section C

I am aware that as a patient of Tele-Mental Health Services information collected from this examination will be entered into a database used for education, statistics, quality improvement, and other purposes permitted or required by law. Information collected in this way will be pooled with other similar information and neither I nor anyone participating in this consultation will be individually or specifically identified. If research is proposed using the database storage of personal health information, then review and approval by the Research Ethics Board will be required beforehand.

I consent to the following sections: ☐A ☐B ☐C

Print name: _____ Signature: _____ Date/Time: _____

Tele-Mental Health Services,
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SickKids® CPRI Child and Parent Resource Institute CHEO

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:_____ copy to physician:_____ copy to file:_____
Date (YYYY-MM-DD) Date (YYYY-MM-DD) Date (YYYY-MM-DD)

Tele-Mental Health Services,
provided by

SickKids® CPRI Child and Parent Resource Institute CHEO

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/Time: _____

Tele-Mental Health Services,
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IMPRINT OR ENTER DETAILS BY HAND

Follow-up Form

Agency #:_____ MRN:_____

To be completed by Physician/Agency

☐ Second Opinion ☐ Follow-up Consultation

Client Name: DOB: YYYY - MM - DD

Physician/Agency Name:

Health Card Number: _____ Version Code: _____ Expiry Date: _____ YYYY - MM - DD

Site:

Date of Original Consultation: _____ YYYY - MM - DD

Name of Original Consultant:_____

Reason for Request (please be specific):

Requested Timeframe: _____

Case Manager/Physician:_____

Date of Request:_____ YYYY - MM - DD

Please return to: Fax 416-813-2189

Dates Clinician is NOT available:

Print Name: _____ **Signature:** _____ **Date/Time:** _____ YYYY - MM - DD

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CPRI
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Print name:_____ Signature:_____ Date/Time: _____ _____

Southwest Ontario Aboriginal Health Access Centre

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/Wanìshi/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.

PLEASE NOTE: 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.