Department of Clinical Services
34 Berczy St. #190 Aurora, ON L4G 1W9

Referral Form

NOTE: YOU MAY ATTACH COPIES OF ASSESSMENTS/REPORTS ETC. TO SUPPORT ANY OF THE QUESTIONS BELOW. IF YOU DO SO, PLEASE INDICATE ON THE FORM AS WELL AS THE CORRESPONSING ATTACHMENT.

1. This is a referral for:

☐ **Behavioural Support Services**
(If behavioural support is requested, please complete Form A)

☐ **Social Work Services**

☐ **Pre-Admission Assessment (refer to Pre-Admission Report Template)**

☐ **Psychiatric Consultation (refer to intake pkg. for Dr. King or Nyhus)**

☐ **Psychological Assessment**

2. Individual requesting referral: ______________________________

3. Date of referral: ______________________________

4. Name of individual referred: ______________________________

   Address: ______________________________

   Tel: ______________________________

5. Individual's Date of Birth: ______________________________

6. Agency involved with referral: ______________________________

7. How long has the individual been supported by agency? ______________________

8. Diagnosis: ______________________________

9. Does the individual have a dual diagnosis or a history of mental health issues?

   ☐ Yes ☐ No

10. If you answered yes, please indicate secondary diagnosis: ______________________

11. Reason For Referral (please attach current data if available) ______________________

Department of Clinical Services
34 Berczy St. #190 Aurora, ON L4G 1W9

12. Is there a history of this behaviour?

13. Relevant History. Can copies of prior reports/assessments be provided or accessed?

14. What efforts have been made to address the issue prior to referral? (please include a description of past interventions/strategies, medications, guidelines etc. used and any relevant data)

Department of Clinical Services
34 Berczy St. #190 Aurora, ON L4G 1W9

15. Were past interventions/strategies successful? Please explain.

16. Are there other professionals involved in the support of this individual? (Please indicate who they are and the extent of their involvement)

DO NOT COMPLETE THE INFORMATION BELOW – FOR DEPT. USE ONLY

Department of Clinical Services
34 Berczy St. #190 Aurora, ON L4G 1W9

17. Action to be taken by Dept.

____

____

____

____

____

____

18. Authorization:

______________________________ ______________________________

Glenn Rampton, C.D., Ph.D. C. Psyh. **Date**
Director of Dept. of Clinical Services

______________________________ ______________________________

Dept. of Clinical Services Personnel **Date**

Referral accepted for:

☐ Psychological Services

☐ Social Work Services ☐ Psychiatric Services