

Please have this form signed by family physician/ nurse practitioner.

To whom it may concern:

Your patient has been referred to the Holland Bloorview Psychopharmacology Clinic, either by yourself or another health care practitioner. One of our intake/referral expectations is that **family physicians / nurse practitioner** play an active role in the treatment of their patients. We will provide assessment and a treatment plan for your patients' behavior problems. In some cases, treatment may be initiated by the clinic, however, once stabilized, the patient will be returned to you for ongoing care, including pharmacotherapy.

Please sign this form and return and fax back to our office fax: 416-422-7036. We will proceed with booking an appointment **only** when both this letter and the **Pre-Clinic Required Information** form are received by our intake department. If your patient does not have a primary care family doctor or pediatrician please access <http://health.gov.on.ca/en/ms/healthcareconnect/public/> or <http://www.health.gov.on.ca/en/common/system/services/chc/locations.aspx> in order to connect family to primary care physician / nurse practitioner.

Family Doctor/Pediatrician Signature

Date

Please Print Name

Date

HOLLAND BLOORVIEW KIDS REHABILITATION HOSPITAL
Psychopharmacology Clinic
 Pre-Clinic visit Required
 Information form
Health Professional

Patient Information:

Name	Sex: M F	DOB:	Age:
Address			
Daytime Phone #			
Health Card # (+ Version Code)			
Weight:		Height/Length:	

Name of Referring Health Professional: _____

Referring Physician / Nurse Practitioner Billing? #: _____ Phone #: _____

Name of Primary Care Physician / Nurse Practitioner if not referring physician / nurse practitioner:

_____ Date of Referral: _____

Reason for Referral: _____

Other current or outstanding referrals for behavior/psychiatry/medication consult for behavior:

Other specialty involvement (include name of professional)

- Psychiatry: _____
- GI specialist: _____
- Neurology: _____
- Other – specify: _____

Medical Diagnoses:*

- | | |
|---|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> ASD <input type="checkbox"/> Global developmental delay <input type="checkbox"/> Genetic disorder <input type="checkbox"/> Sleep issue (describe): <input type="checkbox"/> GI issue (describe): <input type="checkbox"/> Other (describe): | <ul style="list-style-type: none"> <input type="checkbox"/> ADHD <input type="checkbox"/> Intellectual disability <input type="checkbox"/> Seizure disorder |
|---|--|

Other medication relevant information: _____

Behaviors of concern:

- Aggression
- Hyperactivity/Impulsivity
- OCD-like behaviors
- Anxiety
- Self-injury
- Inattention
- Irritability

Investigations

Pre visit requirements for children on atypical antipsychotics (please include with referral)

- CAMESA guidelines bloodwork (fasting glucose or HA1C, lipid profile, LFT, prolactin)
- ECG

Other investigations/reports to be sent if **available/relevant**

- EEG
- MRI
- Diagnostic report
- Psychiatry report
- Genetic bloodwork
- Psychoeducational/psychology assessment
- SLP report
- OT report
- Behavior report
- Other

**PLEASE FILL OUT THIS FORM AND RETURN IT AS SOON AS POSSIBLE TO:
 (APPOINTMENT WILL NOT BE BOOKED UNTIL THIS COMPLETED FORM IS RECEIVED)**

**Client Appointment Services
 Holland Bloorview Kids Rehabilitation Hospital
 150 Kilgour Road,
 Toronto, ON. M4G 1R8
 Fax: 416-422-7036**

Revised: February 23, 2017