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 pediatricians/family physicians 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.

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:

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<tr>
<th>Name</th>
<th>Sex: M F</th>
<th>DOB:</th>
<th>Age:</th>
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<th>Health Card # (+ Version Code)</th>
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Weight:  
Height/Length: 

Name of Referring Health Professional: _____________________________________________

Referring Physician Billing? #: __________________________ Phone #: ___________________

Name of Primary Care Physician if not referring physician __________________________________

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:*

☐ ASD  ☐ ADHD
☐ Global developmental delay  ☐ Intellectual disability
☐ Genetic disorder  ☐ Seizure disorder
☐ Sleep issue (describe):
☐ GI issue (describe):
☐ Other (describe):
Current Agency involvement and therapies:

- Speech language pathology
- Occupational therapy
- Behavior service (specify agency)*: ________________________________
- Ontario ABA program
- Community case management (specify agency): _______________________
- Other (describe): ________________________________

*Referral to behavior services is strongly recommended at/prior to referral. Date of referral: ________________

Communication

- Verbal
- Non-verbal - how does child communicate? _____________________________

MEDICATION HISTORY

Allergies:

Current medications (please include PRN medications) – if more please attach additional information

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<th>Prescriber</th>
<th>Medication name</th>
<th>Indication</th>
<th>Dose</th>
<th>Frequency</th>
<th>Duration of treatment</th>
<th>Effectiveness/Response</th>
<th>Side effects</th>
<th>Other comments</th>
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Previously trialed medications (please include PRN medications)

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<th>Prescriber</th>
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<th>Dose</th>
<th>Frequency</th>
<th>Duration of treatment</th>
<th>Effectiveness/Response</th>
<th>Side effects</th>
<th>Reason for discontinuing and other comments</th>
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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