ANXIETY TREATMENT & RESEARCH CENTRE
St. Joseph's Healthcare Hamilton

PEDIATRIC OCD CONSULTATION TEAM – Referral Form

Referring Physician: _____ **FHT** Yes ☐ No ☐

Address: _____

Tel: _____ Ext: _____Fax: _____ Billing #: _____

Patient Name: _____ (Print) M / F

DOB: _____/_____/_____ (dd/mm/yy) Age: _____ HIN#: _____VC_____

Address: _____PC: _____

Home Phone #: _____Day Phone/Cell #: _____Ext: _____

Parent(s) Name(s): _____

PLEASE SPECIFY Reason for referral: _____
_____
___ _____

Please note existence of the following: (Circle)

1. Repetitive, intrusive (unwanted and/or unpleasant) thoughts **Yes** **No**
2. Repetitive behaviors (e.g. cleaning, checking, rereading) **Yes** **No**
3. Hoarding behaviors **Yes** **No**
4. Skin picking **Yes** **No**
5. Hair Pulling **Yes** **No**
6. Tics: **Motor** **Vocal** **None**
7. Was the patient previously diagnosed with:
   a) **Autism** by Dr. _____
   b) **Asperger's** by Dr. _____
   c) **ADHD** by Dr. _____
   d) **ASD** by Dr. _____
   e) **Developmental delay/CP** by Dr. _____
8. Is the patient acutely suicidal /homicidal? **Yes** **No**
   If YES- please address as emergency (i.e. call COAST, EPT, CAS etc.)
9. Has the patient ever made a suicide attempt? **Yes** **No**
10. Is the patient currently seeing a psychiatrist? **Yes** **No**
    If YES - Name _____
11. Is the patient **currently** taking any prescribed medications?
    If YES – List (+ Dose) _____
12. Has the patient previously had a psychoeducational assessment? **Yes** **No**

    If YES – Please ADVISE the family to bring report to the appointment.
13. Has the patient previously received CBT **Yes** **No**

    If YES, for which condition? _____
14. Does the patient have a serious medical condition we should be aware of? **Yes** **No**
    If YES – Note medical condition(s) _____

Please Fax to the Attention of: Amber Elcock: FAX – 905-521-6120 **DATE: _____**