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 #: __________________ Date of Referral: __________________

Patient Name: ____ (Print) M / F

DOB: _____/_____/________ (dd/mm/yy) Age: _______

HIN#: _______________________________ Parent(s) Name(s): _______________________________

Address: ____

____Postal Code: ________________

Home Phone #: _________________________Day Phone #: ______________________Ext: _______

PLEASE SPECIFY Reason for referral:

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Please note existence of the following: (Circle)

1. Repetitive, intrusive (unwanted and/or unpleasant) thoughts **Yes** **No**
2. Repetitive behaviors (e.g. cleaning, checking, hoarding, rereading) **Yes** **No**
3. Tics **a)** Motor **b)** Vocal **c)** None
4. Was the patient previously diagnosed with:
   a) Autism by Dr. ________________ b) Asperger's by Dr. ________________
   c) ADHD by Dr. _________________ d) Developmental delay/CP by Dr. ______________
5. Is the patient acutely suicidal /homicidal? **Yes** **No**
   If YES- please address as emergency (i.e. call COAST, EPT, CAS etc.)
6. Is the patient currently seeing a psychiatrist? **Yes** **No**
   If YES - Name _____________________________________
7. Is the patient currently taking any prescribed medications?
   If YES – List: ____
8. Has the patient previously had a psychoeducational assessment? **Yes** **No**
   If YES – Please ADVISE the family to bring it to the appointment.
9. Has the patient previously received CBT for OCD? **Yes** **No**
10. Does the patient have a serious medical condition we should be aware of? **Yes** **No**
    If YES – Note medical condition (s) ____

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

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