St. Joseph's Healthcare Hamilton

38 James Street South, 2nd floor
Hamilton, Ontario L8P 4W6
Phone: 905.522.1155 ext. 31725
Fax: 905.527.8291

**YOUTH WELLNESS CENTRE**

# EARLY INTERVENTION STREAM PROVIDER REFERRAL FORM

**Date Format: YYYY/MM/DD**

St. Joseph's Healthcare Hamilton ("SJHH") cannot control what services or systems other providers use and the security of outside electronic communication is not guaranteed. Because of this, it is possible that communications sent to and from SJHH by patients, community agencies or another health care provider may be seen by others. Communications that are sent or received may not be secure and can potentially be forwarded, intercepted, circulated, copied, stored, accessed, deleted or even changed without your knowledge or permission. Additionally, electronic communications can potentially be falsified more easily than handwritten or signed documents.

By checking the below box you acknowledge the risks of electronic communication, that SJHH is not responsible for electronic systems used by other health care providers or third parties, and that SJHH cannot control or secure electronic communications outside of the internal SJHH system.

☐ I have read and acknowledge the above noted risks of electronic communication and agree to proceed with the electronic communication of this referral form.

## INFORMATION ABOUT THE YOUNG PERSON

| | | |
|---|---|---|
| Name: | Preferred Name: | |
| Address: | | |
| City: | Province: | Postal Code: |
| Phone (Preferred): | Is it okay to leave a message? ☐ Yes ☐ No | |
| Phone (Secondary): | Is it okay to leave a message? ☐ Yes ☐ No | |
| Email: | | |
| OHIP #: | VC: | Expiry Date: |
| Date of Birth: | | Age: |
| GP: ☐ Yes ☐ No | GP Name: | GP Phone: |
| Does the young person require language interpretation services? ☐ Yes ☐ No | | |
| Preferred language: | | |

Printed Name: _____ Signature: _____ Disp.: _____ Initials: _____

Printed Name: _____ Signature: _____ Disp.: _____ Initials: _____

Printed Name: _____ Signature: _____ Disp.: _____ Initials: _____

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| **REFERRER INFORMATION** | |
|---|---|
| Today's Date: | |
| First and Last Name: | Position: |
| Billing # (if physician): | Organization: |
| Phone: | Email: |
| Reason for referral: | |
| Does the young person consent to this referral? ☐ Yes ☐ No | |
| Will you or another person from your service have continued involvement with the young person? ☐ Yes ☐ No | |

| **PROFILE OF THE YOUNG PERSON** |
|---|
| Please outline any pertinent information you are aware of in the respective boxes. Boxes can be left blank if you are unsure or if the young person prefers to not provide such information. |
| Home and Environment: |
| Education and/or Employment: |
| Activities and Friends: |
| Drugs, Alcohol, and Addictions: |
| Relationships and Sexuality: |
| Conduct Difficulties and Risk-Taking: |
| Anxiety: |

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| **PROFILE OF THE YOUNG PERSON (CONTINUED)** |
|---|
| Suicide: |
| Depression: |
| Psychosis and Mania: |
| Cognition: |
| Medical Problems: |
| Coping: |
| Supports: |
| Area of Most Concern: |

**SERVICE HISTORY**

Please list any services (including hospital stays) received for the concerns stated above. Estimated dates are acceptable.

| **Agency/Organization** | **Therapy/Treatment Received** | **Date Commenced** | **Date discontinued** (if applicable) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

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| MEDICATION HISTORY | | | | | |
|---|---|---|---|---|---|
| **Medication** | **Current** | **Past** | **Dose** | **Duration** | **Response/Adverse Effects** |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| ADDITIONAL INFORMATION | |
|---|---|
| ☐ Consultation notes or discharge summaries | |
| ☐ Relevant lab and test results | |
| ☐ Medical reports | |
| ☐ Physical findings | |
| ☐ Psychological reports | |
| ☐ Other related reports | |
| **How did you hear about St. Joseph's Healthcare Hamilton's Youth Wellness Centre? Please check all that apply.** | |
| ☐ ReachOutHamilton.ca | ☐ #ReachOut Ad (Ex. Poster or Postcard) |
| ☐ Twitter or Instagram (#ReachOut) | ☐ Other (Please specify): |

| FOR OFFICE USE ONLY |
|---|
| Referral received on: |
| Initial appointment scheduled for: |
| Initial appointment scheduled with (MRC): |
| Referral redirected to: |
| STAR RIW Admission: |
| PHS RIW Waitlist: |