

Springboard Clinic Referral Form: Online ADHD/Mental Assessment

We are pleased to offer online ADHD/Mental Health Assessments for adults seeking a specialty consult in the province of Ontario. Online assessments are limited to adults (18 years of age or older) living outside of the GTA. Suitability for online services will be determined during a phone/video consultation with a Springboard psychologist prior to scheduling any appointments.

We require this referral form to be completed prior to booking a consultation. As we are unable to offer ongoing medical and pharmaceutical care over video, it is imperative that patients have a primary care physician 'close to home' able to provide ongoing care post-assessment.

Upon completion of the assessment our psychiatry team will share a detailed note with clinical impressions and treatment recommendations with the referring physician. Should we recommend psycho-stimulants in the consult note, we leave it to your clinical relationship to determine if a patient is a suitable and reliable candidate for treatment with a psycho-stimulant.

Of note, our medical team is open to connecting with patients' primary physician directly should questions or concerns arise. We thank you for taking the time to help us determine whether your patient is a good fit for this service.

Patient Information:

Surname: _____ Given Name(s): _____
D.O.B.: (dd/mm/yyyy): _____ Sex: M / F
Health Card No: _____ Phone No.: _____
Address: _____ Email: _____

Referral:

Reason for Consultation:

Significant Concurrent Problems:

Current Medications:

Past Psychiatric Medications:

Past Psychiatric/Medical History:

Other Relevant History:

Suitability for Online Assessment:

Do you feel this client is an appropriate candidate for an online (distance) assessment with our specialist team?

Are there any safety concerns with this client participating in online services?

How frequently do you see this client?

Do you agree to manage this client's ongoing care, post-assessment?

Are there any other notes you would like to share about this client pursuing an online assessment?

Referring Physician Information:

Name: _____

OHIP Billing No.: _____

Phone No.: _____

Fax No.: _____

Date

Physician Signature

Please fax the completed form to (416) 901-3079 or email it to info@springboardclinic.com