Springboard Clinic
1055 Yonge St., Suite 306
Toronto ON M4W 2L2
Tel: 416.901.3077

Springboard Clinic Referral Form:

Online ADHD/Mental Assessment

We are pleased to offer online ADHD assessments for adults seeking a specialty consult in the province of Ontario. We are passionate about the services we offer and committed to supporting patients as they embark on their mental health journeys. Please note that our 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 care over video post-assessment, 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. 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:

_____

_____

_____

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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