

## Springboard Re-Referral Form

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

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### INFORMATION FOR REFERRING PHYSICIANS

*This form is exclusively for the use of primary health care practitioners seeking to refer patients who have previously met with a Springboard physician, and have since been discharged or were last seen over a year ago. If you are referring a patient for assessment, please use the appropriate referral form.*

**We require this referral form to be completed in full prior to booking a consultation.**

Our specialist physicians work with patients to provide medical review and pharmacological support for ADHD-specific concerns on a short-term basis. Once a patient's medication has been optimized, the patient is discharged to the care of their primary health care provider. At that time, the patient's primary care provider will be responsible for taking over the patient's care and ongoing medication needs.

Should questions or concerns arise that cannot be addressed by their primary health care provider, discharged clients may be re-referred for reassessment of their ADHD treatment plan by one of Springboard's specialist physicians. Updated recommendations and detailed instructions will then be sent to the referring physician in order to support the continued management of their patient's medication needs.

**Of note, this form is also available in fillable PDF format. Please visit our website: [www.springboardclinic.com/physician-referrals](http://www.springboardclinic.com/physician-referrals)**

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### PHYSICIAN SUPPORT SERVICES

If the primary health care provider of a past or present Springboard patient has any questions or concerns about **managing their patient's ADHD medications**, a phone consultation between the primary healthcare provider and a Springboard physician is likely more appropriate in lieu of a re-referral to Springboard Clinic. We would be happy to provide guidance regarding dosage changes and medication management, or answer general questions about ADHD diagnoses and treatment.

Please contact our office by phone (416-901-3077), fax (416-901-3079), or email ([info@springboardclinic.com](mailto:info@springboardclinic.com)) to schedule a phone call with a Springboard physician.

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<b>Patient information:</b> <i>(may attach label)</i>			
Name:		DOB (dd/mm/yyyy):	
Health Card:	VC:	Telephone:	
Email Address:		Address:	
<b>Referring practitioner:</b>			
Name:		OHIP Billing No.:	CPSO #:
Telephone:		Are you this patient's primary care provider? Y / N	
Fax:		Do you agree to implement/monitor recommendations and	
Address:		provide ongoing follow-up? Y / N	
<b>Specific issues or concerns requiring re-assessment:</b> <i>(please check all that are relevant/appropriate)</i>			
<input type="checkbox"/> ADHD medication type or dosage adjustment <i>(a phone call may be more appropriate in lieu of re-referral)</i> <input type="checkbox"/> Mood / anxiety symptomatology <input type="checkbox"/> Sleep <input type="checkbox"/> Major life event <input type="checkbox"/> Poor symptom management <input type="checkbox"/> Adverse reaction <input type="checkbox"/> Other:			
<b>Additional information regarding reason for re-assessment:</b> <i>(if appropriate)</i>			
<b>Summary of medical care or recent changes in patient health status (if applicable):</b> <i>(attach all relevant documentation):</i>			
<b>Current Medications:</b>			
<b>PHYSICAL EXAMINATION:</b> <i>(If you are unable to conduct a physical examination when completing this form due to COVID, please provide us with your most up-to-date information. Please also attach a growth chart to this referral, if available.)</i>			
Height:	Weight:	Blood Pressure:	Heart Rate: