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

Springboard Re-Referral Form for Children/Adolescents (Ages 6-17)

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

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.

Springboard Clinic provides consulting medical services for clients under the age of 18. Upon completion of the consultation our team will share a detailed note with clinical impressions and treatment recommendations with the referring physician. **We do not offer prescriptions or ongoing medical care post-consultation for clients under the age of 18.** We do, however, accept re-referrals from physicians should further consultation be required.

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, and can be scheduled via fax (416-901-3079) or email (info@springboardclinic.com).

INFORMATION FOR PATIENTS

Please ensure your patient is aware that a referral is being made on their behalf.

Springboard Clinic will make three attempts to contact the patient regarding this referral. If the patient cannot be reached, the referring provider will be notified. Note the number will appear as a blocked caller ID.

Please also ensure your patient is aware that Springboard Clinic provides consulting medical services for clients under the age of 18, and that we will not provide prescriptions or ongoing medical care post-consultation.

RE-REFERRAL COMPLETION CHECKLIST

We require this referral form to be completed *in full* to proceed with a consultation request. A generic referral form will not be considered.

In order to ensure the completeness of this consultation request, please refer to the checklist below:

Please attach the following:

- ☐ Completed Springboard Re-Referral Form
- ☐ Summary of medical care or recent changes in patient health status, since patient was last seen at Springboard Clinic. Please attach copies of any relevant documents, such as psychiatric consultations or discharge summaries, psychoeducational, speech/language, mental health, or other relevant assessment reports.
- ☐ Copy of growth chart (if available)

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PATIENT INFORMATION *(may attach label)*

Name: _____

DOB (dd/mm/yyyy): _____

Gender: _____ Pronouns: _____

Email Address: _____

Health Card: _____ Version Code: _____

Telephone: _____

Alt Telephone: _____

Address: _____

_____

CUSTODY STATUS

☐ Lives with both parents/ Married/ Common Law
☐ Joint Custody
☐ Sole Custody
☐ Other (please specify): _____

Guardian 1:

Name: _____

Telephone: _____

Guardian 2 (if applicable):

Name: _____

Telephone: _____

REFERRING PRACTITIONER INFORMATION

Practitioner Type: ☐ Family Physician ☐ Nurse Practitioner ☐ Psychiatrist ☐ Other: _____

Name: _____ OHIP Billing No.: _____

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

_____

Specific issues or concerns requiring re-assessment: (e.g., reassessment of treatment plan, major life event, poor symptom management, adverse reaction):

☐ I confirm this client is *not* being referred for the purpose of prescribing their medications (see **Physician Support Services** on page 1).

Significant concurrent problems:

Summary of medical care or recent changes in patient health status: *(attach all relevant documentation)*:

Current Medications:

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Previous Medication Trials and Reason for Discontinuation:

PHYSICAL EXAMINATION

The following information must be provided for *all clients under the age of 18* as the majority of consultations are taking place online.

*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.

Height:

Weight:

Blood Pressure:

Heart Rate:

Chest Examination:

Cardiovascular Examination (CVS):

Other (if applicable):

FORM COMPLETED BY:

Name: _____ CPSO #.: _____

Date: _____ Signature: _____