springboard

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

Springboard Clinic Re-Referral Form for Adults (Age 18+)

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.

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.

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 the 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.

RE-REFERRAL COMPLETION CHECKLIST

We require this referral form to be completed 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 consultation notes, lab results, reports, and other relevant medical records.

Supplementary materials (if available):

- ☐ Recent blood work (within the last 12 months)
- ☐ Recent ECG (within the last 12 months)

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PATIENT INFORMATION *(may attach label)*

Name: ______________________ DOB (dd/mm/yyyy): ______________________

Health Card: ______________ Version Code: ______ Gender: __________ Pronouns: __________

Telephone: ______________________ Email Address: ______________________

Alt Telephone: ______________________ Address: ______________________

____

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 provide ongoing follow-up? Y / N

Address: ______________________

____

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:

Previous Medication Trials and Reason for Discontinuation:

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Risks or Safety Concerns:

PHYSICAL EXAMINATION

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 copies of recent blood work and ECG results (within the last 12 months), if available.

Height:

Weight:

Blood Pressure:

Heart Rate:

Other (if applicable):

FORM COMPLETED BY:

Name: ___________________________________ CPSO #.: ____

Date: _____________________________________ Signature: ____