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

Springboard 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

We are pleased to offer ADHD/Mental Health and Psychoeducational Assessments for individuals seeking a specialty consult in the province of Ontario.

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 assessment 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 post-assessment should further consultation be required.

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.

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.

Please ensure your patient is aware of the fees associated with our services, which are tax exempt and eligible for insurance reimbursement:

- Child (6-12 years) or Student (13-17 years) ADHD Assessment: $2508
- Psychoeducational Assessment (6+): $4180
- Coaching / Psychotherapy: $209/hr

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.

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 Referral Form
- ☐ Any relevant documents, such as prior 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

_____

Reason for consultation (current symptoms and functioning, behavioural concerns, etc.):

What specific service are you referring your patient for?

☐ ADHD/Mental Health Assessment ☐ Psychoeducational Assessment ☐ Coaching / Psychotherapy

☐ Other: _____

Significant concurrent problems:

Past psychiatric medical history *(attach all relevant documentation)***:**

Other relevant history:

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Current Medications:	**Previous Medication Trials and Reason for Discontinuation:**
Risks and Safety Concerns:	

Suitability for Online Assessment (COVID-19): *We would appreciate your help in determining if this client is a suitable candidate for an online assessment, or if they should be put on a waitlist for in-person assessment services.*

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

Notes:

PHYSICAL EXAMINATION

The following information must be provided for *all clients under the age of 18* as due to current limitations the majority of assessments 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: _____