Springboard Clinic
1055 Yonge St., Suite 306, Toronto ON M4W 2L2
Tel: 416.901.3077 Fax: 416.901.3079

# Springboard Referral Form (Ages 6+)

**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.**

Upon completion of the assessment, our team will share a detailed note with clinical impressions and treatment recommendations with the referring physician. Depending on the clinical impression, client's goals and recommended plan, an episode of care may be offered with a physician at Springboard Clinic. In all cases, a follow-up plan will be communicated with the client and referring physician. Of note, Springboard Clinic provides consulting medical services; care will be transferred back to the referring physician once medication has been optimized. 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 post discharge, further support can be accessed by any of the following:

- Physician-to-physician phone consultation with Dr. Ainslie Gray
- Re-referral to Springboard Clinic
- Phone consultation with a Springboard physician

## 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 and the patient's phone must be capable of accepting such calls.

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

- Springboard Benchmark Assessment (child/student): $2,616
- Springboard Benchmark Assessment (18+): $2,180
- Springboard Psychological Assessment (child/student): $2,616
- Springboard Psychological Assessment (18+): $2,180
- Springboard Psychoeducational Assessment (6+): $4,300
- Coaching/Psychotherapy: $218/hr

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If you are referring a Child/Student:

**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)

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.

If you are referring an Adult (18+):

**REFERRAL COMPLETION CHECKLIST**

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 reports
- Recent bloodwork (within the last 12 months, if available)
- Recent ECG (within the last 12 months, if available) – There are certain situations during which cardiac information is required for the Springboard Team to make detailed treatment recommendations.
- History and Examination Prior to starting ADHD medication form completed

- Information not available at this time, though can be pursued by the referring physician if recommended

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# Springboard Referral Form

**Please fill out the applicable sections for your patient and fax the completed form to (416) 901-3079 or email it to info@springboardclinic.com.**

| **PATIENT INFORMATION** *(may attach label)* | **CUSTODY STATUS (For Children/Students)** |
|---|---|
| Name:<br>DOB (dd/mm/yyyy):<br>Gender: _____ Pronouns:<br>Email Address:<br>Health Card:_____ Version Code:<br>Telephone:<br>Alt Telephone:<br>Address: | Lives with both parents/ Married/ Common Law<br>Joint Custody<br>Sole Custody<br>Other (please specify):<br>**Guardian 1:**<br>Name:<br>Telephone:<br>**Guardian 2 (if applicable):**<br>Name:<br>Telephone: |

**REFERRING PRACTITIONER INFORMATION**

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

Name: _____
Telephone: _____
Fax: _____
Address: _____
_____

OHIP Billing No.:_____
Email address: _____
Are you this patient's primary care provider? **Y / N**
Do you agree to implement/monitor recommendations and 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?**

☐ Benchmark Assessment ☐ Psychological Assessment ☐ Psychoeducational Assessment

☐ Coaching/Therapy ☐ Other: _____

**Significant concurrent problems:**

| **Past psychiatric medical history** *(attach all relevant documentation)***:** | **Other relevant history:** |
|---|---|
| **Current Medications** *(attach medication list):* | **Previous Medication Trials and Reason for Discontinuation:** |

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**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 - FILL ONLY FOR PATIENTS UNDER 18**

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):**

**(OPTIONAL) HISTORY AND EXAMINATION PRIOR TO STARTING ADHD MEDICATION**

**ONLY FILL FOR PATIENTS 18+**

Psychostimulant medication is a common treatment recommendation following a diagnosis of ADHD. Blood pressure, pulse and cardiac auscultation are recommended prior to a stimulant start. In addition, an ECG is sometimes recommended (e.g. in patients taking a tricyclic antidepressant, on other medication that might prolong the QT interval, etc.).

Please complete the following to help the consulting physician determine what investigations may or may not be needed.

| | |
|---|---|
| Shortness of breath with exercise (more than others of the same age) in the absence of an alternate explanation (e.g. asthma, sedentary lifestyle, obesity) | Y / N |
| Poor exercise tolerance (in comparison with others) in the absence of an alternate explanation (e.g. asthma, sedentary lifestyle, obesity) | Y / N |
| Fainting or seizures with exercise, startle or fright | Y / N |
| Palpitations brought on by exercise | Y / N |
| Family history of sudden or unexplained death including sudden infant death syndrome, unexplained drowning or unexplained motor vehicle accidents (in 1st or 2nd degree relatives) | Y / N |

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| | |
|---|---|
| Personal or family history (1st or 2nd degree relatives) of non-ischemic heart disease such as:<br>• Long QT syndrome or other familial arrhythmias<br>• Wolff-Parkinson-White syndrome<br>• Cardiomyopathy<br>• Heart transplant<br>• Pulmonary hypertension<br>• Unexplained motor vehicle collision or drowning<br>• Implantable defibrillator | Y / N |

☐ Information not available, though can be ordered by the referring physician if recommended.

**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.

**Height:** **Weight:** **Blood Pressure:**

**Thyroid Exam:** ☐ Unremarkable ☐ Abnormal **Cardiac Auscultation?** ☐ Normal ☐ Abnormal

Organic (not functional) murmur present? Y / N

Other abnormal cardiac findings (e.g. sternotomy incision, etc.)? Y / N

**FORM COMPLETED BY:**

Name: _____ CPSO #.: _____

Date: _____ Signature: _____