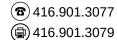


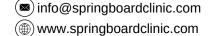
Referral Form (Ages 18+)

Springboard is an ADHD clinic that provides assessment and treatment services for children, teens and adults.

Once completed, please fax this form to **416-901-3079**. If preferred, you may also use our <u>online e-referral form</u> (via Ocean).

Patient Information	
Name: I	DOB (dd/mm/yyyy):
	Version Code:
	Pronouns:
Telephone:	Email Address:
Address:	
Reason for Referral Select all that apply: Attention Deficit/ Hyperactivity Disorders (ADD Psychoeducational (PE)/ Learning Disabilities Autism Spectrum Disorder Diagnostic Assessmant (add on to ADHD assessment) Presenting concerns (current symptoms and functions)	and Disorders nent (add on to ADHD or PE assessment) sment)
Psychiatric/Medical History Please attach all relevant documents.	Other Relevant Medical History Please attach all relevant documents.



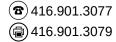


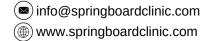


PATIENT NAME:			

Previous Diagnosis?	Current Medication and D	osage (allach list).				
□ No	Medication	Dose	Date			
☐ Yes (please specify):						
						
Please attach previous assessment.						
Physical Examination						
Please provide us with your most up-to-date info	ormation.					
Height: Weight: _						
	ט	lood Pressure:	 			
Thyroid Exam: Unremarkable Abnormal						
Cardiac Auscultation? Normal Abnormal						
Organic (not functional) murmur present	? □ No □ Yes					
Other abnormal cardiac findings (e.g. ste	ernotomy incision, etc.)?	No Y	es			
Is there a prior ECG? ☐ No ☐ Yes	(please attach)					
	Normal					
	Abnormal Findings:		 			
Referring Practitioner Information	tion					
Name:	OHIP Billing No:					
Telephone:						
Address:						
			· · · · · · · · · · · · · · · · · · ·			
Type of Practitioner (select one):						
☐ General Practitioner ☐ Ps	ychiatrist	☐ Nurse Practitio	ner			
Springboard Clinic provides consulting med	ical services alongside no	n-OHIP covered ps	sychological			
services. Depending on the clinical impressi	ion, patient's goals and re	commended plan,	an episode of			
care may be offered with a physician at Spri	ingboard Clinic following t	he consultation. Fo	ollowing			
discharge, the patient's primary care provide	er (or associated healthca	re team) will be res	sponsible for			
taking over the patient's care and ongoing n	nedication needs.					
Signatura	D	ato:				
Signature:	Da	ate:				
CPSO #:						







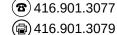
PATIENT NAME:	

OPTIONAL: History and Examination Prior to Starting ADHD Medication

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)	□ No □ Yes
Poor exercise tolerance (in comparison with others) in the absence of an alternate explanation (e.g. asthma, sedentary lifestyle, obesity)	□ No □ Yes
Fainting or seizures with exercise, startle or fright	□ No □ Yes
Palpitations brought on by exercise	□ No □ Yes
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)	□ No □ Yes
Personal or family history (1st or 2nd degree relatives) of non-ischemic heart disease such as: • Long QT syndrome or other familial arrhythmias • Wolff-Parkinson-White syndrome • Cardiomyopathy • Heart transplant • Pulmonary hypertension • Unexplained motor vehicle collision or drowning • Implantable defibrillator	□ No □ Yes



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