springboard

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 online e-referral form (via Ocean).

Patient Information

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

Health Card Number: _____ Version Code: _____

Gender: _____ Pronouns: _____

Telephone: _____ Email Address: _____

Address: _____

Reason for Referral

Select all that apply:

- ☐ Attention Deficit/ Hyperactivity Disorders (ADD/ADHD)
- ☐ Psychoeducational (PE)/ Learning Disabilities and Disorders
- ☐ Autism Spectrum Disorder Diagnostic Assessment (add on to ADHD or PE assessment)
- ☐ Memory Assessment (add on to ADHD assessment)

Presenting concerns (current symptoms and functioning, behaviour concerns, etc):

Psychiatric/Medical History
Please attach all relevant documents.

Other Relevant Medical History
Please attach all relevant documents.

PATIENT NAME: _____

Previous Diagnosis?

☐ No

☐ Yes (please specify):

_____

_____

Please attach previous assessment.

Current Medication and Dosage (attach list):

Medication	*Dose*	*Date*

Physical Examination

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? ☐ No ☐ Yes

Other abnormal cardiac findings (e.g. sternotomy incision, etc.)? ☐ No ☐ Yes

Is there a prior ECG? ☐ No ☐ Yes (please attach)

- ☐ Normal
- ☐ Abnormal Findings: _____

Referring Practitioner Information

Name: _____ OHIP Billing No: _____

Telephone: _____ Fax: _____

Address: _____

Type of Practitioner (select one):

☐ General Practitioner ☐ Psychiatrist ☐ Nurse Practitioner

Springboard Clinic provides consulting medical services alongside non-OHIP covered psychological services. Depending on the clinical impression, patient's goals and recommended plan, an episode of care may be offered with a physician at Springboard Clinic following the consultation. Following discharge, the patient's primary care provider (or associated healthcare team) will be responsible for taking over the patient's care and ongoing medication needs.

Signature: _____ Date: _____

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