springboard

Referral Form (Ages 6-17)

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: ____

Custody Status:

☐ Lives with both parents/married/common law ☐ Joint Custody

☐ Sole Custody ☐ Other (please specify): ____________________

Reason for Referral

Select all that apply:

☐ Attention Deficit/ Hyperactivity Disorders (ADD/ADHD)

☐ Psychoeducational/ Learning Disabilities and Disorders

☐ Autism Spectrum Disorder Diagnostic Assessment (add on to one of the assessments above)

☐ Medication Consult offered in conjunction with psychological services for patients with a previous diagnosis of ADHD (please include reports, current medication)

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

Previous Diagnosis?

☐ No

☐ Yes (please specify): ____

Please attach previous assessment.

PATIENT NAME: ___________________________

Psychiatric/Medical History

Please attach all relevant documents.

Current Medication and Dosage (attach list):

Medication	*Dose*	*Date*

Physical Examination

Please also attach a growth chart to this referral, if available.

Height: ________________ Weight: ______________________ Blood Pressure: ___________

Heart Rate: _____________ Chest Examination: ____________ CVS: ____________________

Other (if applicable): ____

Referring Practitioner Information

Name: __________________________________ OHIP Billing No: __________________________

Telephone: ______________________________ Fax: ____________________________________

Address: ____

Type of Practitioner (select one):

☐ General Practitioner ☐ Paediatrician ☐ 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 #: ___________