

Referral Form (Ages 6-17)

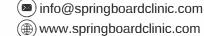
Springboard is an ADHD clinic that provides assessment and treatment services for children, teens and adults.

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

Patient Information			
Name:	DOB (dd/mm/yyyy): 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			
	Disorders ment (add on to one of the assessments above) n psychological services for patients with a previous urrent medication)		
Previous Diagnosis? ☐ No			
☐ Yes (please specify):			









PATIENT NAME:	

Psychiatric/Medical History	Current Medica	Current Medication and Dosage (attach list):			
Please attach all relevant documents.	Medication	Dose	Date		
Physical Examination					
Please also attach a growth chart to this referral, if a	available.				
Height: Weight:	Blo	ood Pressure:			
Heart Rate: Chest Examination					
Other (if applicable):					
Referring Practitioner Information					
Name:					
Telephone:					
Address:	Fax:				
Address.			·		
Type of Practitioner (select one):					
☐ General Practitioner ☐ Paediatrician	☐ Psychiatrist	☐ Nurse Practitio	ner		
General Fractitionel Faculatifician		Nuise Flacillo	ilei		
Springhoord Clinia provides consulting modical	convices alongside non	OUID sowered pr	sychological		
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 (c	•		ū		
taking over the patient's care and ongoing med		s todan, will be rec	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
,					
Signature:	Dat	e:			
CPSO #:					



