

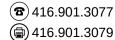
Referral Form (Ages 6-17)

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).

DOB (dd/mm/yyyy):					
Version Code:					
Pronouns:					
Email Address:					
☐ Joint Custody					
☐ Other (please specify):					
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):					





306-1055 Yonge Street

Toronto ON M4W 2L2



PATIENT NAME:	

Psychiatric/Medical History	Current Med	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 availa	able.				
Height: Weight:	ĺ	Blood Pressure:			
Heart Rate: Chest Examination: _					
Other (if applicable):					
Referring Practitioner Information					
Name:	OHIP Billing No:				
Telephone:					
Address:					
Type of Practitioner (select one):					
☐ General Practitioner ☐ Paediatrician ☐	Psychiatrist	☐ Nurse Practitio	ner		
I acknowledge that Springboard Clinic provides consultative care and does not assume ongoing care					
of this patient. I also acknowledge that I am the primary care provider for this patient and can act on					
the recommendations made by Springboard Clinic. Clinic recommendations may include a medication					
plan, where appropriate, specifying a recommended medication and outlining a titration schedule.					
Springboard physicians may offer an episode of care when appropriate. If I have questions about the					
medication plan or the patient's response to treatment at any time, I understand that I may consult with clinic physicians via e-consultation or telephone call.					
Signature:	C	ate:			
CPSO #:					



