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
- ☐ Sole Custody
- ☐ Joint 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.

Toronto Clinic:
40 Holly St, Suite 701, Toronto ON M4S 3C3
torontoadmin@springboardclinic.com
416.901.3077 416.901.3079

Oakville Clinic:
209 Oak Park Blvd, Suite 201, Oakville ON L6H 0M2
oakvilleadmin@springboardclinic.com
416.901.3077 416.901.3079

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

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: _____ Date: _____

CPSO #: _____