Children's Hospital
London Health Sciences Centre

Fax Cover Sheet

Date			Child & Adolescent Mental Health Care Program 800 Commissioners Rd E Zone B, 8th Floor London, Ontario N6A 4G5 **Intake Phone: 519-667-6640** **Fax: 519-667-6814**
To			
Fax #			
From	Centralized Intake Office- Ambulatory Child & Adolescent Mental Health Program		
Subject	**New Outpatient Referral Form**	Total Pages: 6	

Dear Referral Partner(s);

Re: New Referral Form for Outpatient Services

In order to assist our program in determining whether our services best meet the needs of the patient you are referring, we have created a new referral form that will be implemented immediately. We kindly ask that you complete the referral with the patient and family in full prior to sending to us.

We have also attached further information regarding our program. We will still require families to complete the intake questionnaire, which is sent to the patient and families once the referral is reviewed by the intake team.

Should you have any questions or concerns regarding the new referral form please do not hesitate to reach out to the intake office at 519-667-6640.

Sincerely;

Centralized Intake Office
Ambulatory Child & Adolescent Mental Health Care Program

Children's Hospital
London Health Sciences Centre

Child & Adolescent Mental Health Care Program – Outpatients Referral Form

- Please fax all referrals to Centralized Intake: 519-667-6814
- Please direct any inquiries to 519-667-6640
- **Please complete the referral form in full**
- **When submitting this referral, please include available supporting documents and reports (e.g., previous mental health and psychiatric assessments, psychological reports, separation and/or custody agreements**

800 Commissioners Road East
Zone B, 8th Floor, P.O. Box 5010
London, Ontario, N6A 5W9
Phone: 519-667-6640
Email: camhintake@lhsc.on.ca

The Child and Adolescent Mental Health Care Program provides clinical services for children and youth up to 17 years of age and their families. We offer assessment and treatment for children and adolescents with moderate – severe mental health difficulties of an internalizing nature in the catchment area of London – Middlesex.

Referrals for the following difficulties are redirected at intake or at time of assessment to resources in the community that are better able to meet the child's/youth's needs:

- *Children and adolescent who require continuous care or shelter, as opposed to treatment*
- *Referrals for assessments regarding custody and access, child welfare, or youth justice*
- *Behavioural problems*
- *Conduct Disorder (CD), and Oppositional Defiant Disorder (ODD)*
- *Substance Abuse*
- *Neurodevelopmental Disorders, such as Autism Spectrum Disorder, Intellectual Disability, Communication Disorders (e.g., stuttering, language disorders)*
- *Attention-Deficit/Hyperactivity Disorder, Learning Disorders, and Motor Disorders (e.g., Stereotypic Movement Disorder)*
- *Physical illness without an associated mental health problem*
- *Elimination Disorders (Enuresis, Encopresis)*
- *Sleep Disorders*

PATIENT INFORMATION

Patient's Name: _____ DOB (dd/mm/yy): _____ Age: _____

Address: _____

City: _____ Postal Code: _____

Health Card Number (including version code): _____

Phone Number: _____ Cell Phone Number: _____

Is the patient agreeable to this referral: ☐ Yes ☐ No

PARENT/GUARDIAN INFORMATION

***Use Box 2 to provide information of second parent when residence differs and there is joint/shared custody*

Custody Status: _____

Box 1

Name(s): _____

Relationship to Child: _____

Address: _____

City: _____ Postal Code: _____

Phone: _____

Box 2

Name(s): _____

Relationship to Child: _____

Address: _____

City: _____ Postal Code: _____

Phone: _____

REFERRING PHYSICIAN/NP (mandatory for accessing service)

Name of Referring Physician (please print): _____ Billing Number: _____

Phone Number: _____ Fax Number: _____

Physician Address: _____

Family Physician (if different from referring physician): _____

Phone Number: _____ Fax Number: _____

SAFETY

Please provide details on the level of severity of the mental health concerns and the effect on the patients functioning:

Please check off the following that apply to your patient's history/current presentation:

Concern	Current	Past	Details	Concern	Current	Past	Details
Self-Harm				Suicidal Ideation			
Suicide Attempt(s)				Substance Use			
Trauma				Anxiety			
Depression				Obsessions/Compulsions			
Hallucinations				Delusions			
Hyperactivity				Developmental Delay			
Violence/Acts of Aggression				Oppositional Behaviour			

RELEVANT MEDICAL HISTORY

Patient's Current Diagnosis:

Patient's Current Medications (including dose):

ACCESS TO MENTAL HEALTH SUPPORTS/SERVICES:

Past Mental Health treatment/diagnosis/admission: ☐ Yes ☐ No If yes, please specify: _____

_____

_____

Current Mental Health Support: ☐ Yes ☐ No If yes, please specify: _____

_____

_____

Has this patient been referred to other Mental Health supports other than the Child & Adolescent Mental Health Outpatients Program? ☐ Yes ☐ No If yes, please specify: _____

_____

_____

Child & Adolescent Mental Health Care Program Referral Package
Information for Families

Thank you for considering a referral to the Child and Adolescent Mental Health Care Program. In order to help us determine whether our service best meets the needs of your child/youth, we ask that the enclosed intake questionnaire be completed by both a caregiver and youth (for ages 12 years and older) or by a caregiver (for children 11 years and younger). We request that family physicians complete the physician's referral page. If you do not have a family physician, you can obtain one via http://www.health.gov.on.ca/en/ms/healthcareconnect/public/.

Please return the completed questionnaires to either the physician making this referral on your behalf, or submit to the Child and Adolescent Mental Health Care Program, Centralized Intake Department by mail, fax or secure email. Once your completed questionnaire is received we will begin processing the referral. In order for us to provide the best services for you and your family, please include any previous psychiatric assessments, psychoeducational assessments, and/or IEP's.

Once the completed referral package is received, the package will be reviewed by intake staff to determine if the services offered within our program would best meet the needs of your child. If it is determined that your child would be best served by another agency or service, you will receive a letter informing you of this with resource recommendations.

Accepted patients will be offered a diagnostic assessment and recommendations will be provided. These recommendations may include treatments offered through our program or services available in the community.

If you need assistance completing the referral information package due to language, literacy, or other such barriers, please contact the Centralized Intake Office. Children's Hospital provides various supports to families receiving care including the Family Advisory Council and the Child Life Program to assists patients and families with identified needs.

If your child is in need of crisis support, please contact Tandem at (519) 433-0334 or visit the Emergency Department at Children's Hospital.

Please see the next page for further information about what you can expect if you are accepted to our program.

Sincerely;
Centralized Intake Office
Ambulatory Child & Adolescent Mental Health Care Program

Child & Adolescent Mental Health Care Program Referral Package
Information for Families

The information below about our program may help you decide if our services are a good fit for your family's needs:

- We offer assessment and/or treatment for children 17 & under who are experiencing acute mental health difficulties primarily with mood, suicidality, self-harm, or anxiety symptoms.
- Our program provides mostly group-based interventions and individual treatment is offered only when clinically indicated.
- For those children and youth accepted for hospital-level service (including outpatient), a combination of medication and therapy is often recommended to help them feel better.
- Sessions may be virtual or in person; depending on hospital guidelines, there may not be flexibility around this.
- Treatment is skills-based and/or focused on goals created together with the child/youth and caregivers. For success, goals need to be regularly worked on between appointments.
- Parents/caregivers play an active role in assessment and treatment and are encouraged to attend sessions as recommended.
- Treatment length is typically 12-20 sessions, with regular attendance expected. Treatment is usually weekly, but could be more or less frequent depending on the treatment. We recognize this can be a large time commitment but it is needed to get the most benefit.
- Outpatient assessment and treatment appointments are typically offered between 8 a.m. and 4 p.m. or 9 a.m. and 5 p.m. Monday to Friday. We understand this is during regular working and school hours. When requested, we are able to provide documentation to confirm appointment attendance.
- It is expected that children/youth and/or caregivers will attend all scheduled appointments. If canceling an appointment, staff will require at least 2-days notice. Unfortunately, our available appointment slots are limited - we want to be fair to all needing services in rescheduling.
- Repeated nonattendance for sessions (e.g., 3 missed sessions or frequent cancelled sessions) may mean that further services may not be able to be offered. Our team will do our best to help address any barriers to treatment and suggest options if we are unable to provide treatment as recommended.
- In many cases, treatment will be most successful if any caregivers involved in the child's life are supportive of the child/youth receiving services and will support the child/youth to attend sessions and follow through with treatment plans. **Please include a copy of the separation agreement if available with this form.**
- **We are unable to provide evaluations or recommendations related to custody or access**

We encourage you to ask questions and share information in your appointments. Please take some time to think about what areas you hope to have help with. If you have any questions or difficult

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Child & Adolescent Mental Health Care Program
Instructions for returning questionnaires

In order for us to provide the best services for you and your family, please include any previous psychiatric assessments, psychoeducational assessments, and/or IEP's.

Please return the completed questionnaire(s) to the Child and Adolescent Mental Health Care Program, Centralized Intake Department by mail, fax, or secure email.

- **Mail to:** Child & Adolescent Mental Health Care Program, Intake Office
  800 Commissioners Rd. E., Zone B, 8th Floor, Room 070, P.O. Box 5010
  London, Ontario N6A 5W9

- **Fax:** 519-667-6814

- **Secure Email:** Go to https://fs.lhsc.on.ca/

Preferred method for returning questionnaire.

1) Click Start
2) Enter your email address, Confirm your email address
3) Enter the email address of a London Hospital Employee or affiliate: camhintake@lhsc.on.ca
4) Click "Choose File" to browse to your file and double click it
5) Click "Add File" to add the file to your safe, repeat for additional files
6) When all files have been added, click "Send Files"

London hospital employees and affiliates will receive an email notifying them that the file is available and will use their corporate ID and Password to log in to retrieve the file.

Sincerely;
Centralized Intake Office
Ambulatory Child & Adolescent Mental Health Care Program

Children's Hospital
London Health Sciences Centre

Child and Adolescent Mental Health Care Program:
Consent Form for E-mail Distribution

Would you be interested in receiving e-mail communications from us about resources available either within our program or in the community that may be of assistance to your family while you are waiting for services? The e-mail will be sent from camhintake@lhsc.on.ca, so others who inadvertently see this e-mail may recognize this as being sent from our program and/or the hospital. You can contact us by phone at (519) 667-6640 or by responding to the e-mail if you wish to be removed from the e-mail distribution list.
Although general information and available resources will be shared via e-mail, please note that no specific information about your child or their care will be communicated by e-mail. Given that e-mails are not a secure form of communication, we also ask that any questions or concerns you have about your child's care while you are waiting for services be directed by phone to our Intake department at (519) 667-6640 and not via e-mail.

Would you be interested in being added to our e-mail distribution list? YES NO

Patient's Name: _____

Patient's E-mail address: _____

Patient's signature (providing consent): _____

Date: _____

Parent/Guardian's Name(s): _____

Parent/Guardian's Email(s): _____

Parent/Guardian's signature (providing consent): _____

Date: _____