

CHILD and YOUTH MENTAL HEALTH REFERRAL

PHONE: 613-544-3400 ext. 23406 or ext. 22085 | FAX: 613-544-7623

If you are a health care practitioner in KFL&A please submit a referral through our Centralized Triage with the Maltby Centre website's Connect Now link with the KFL&A Service Request Form button.

Date of Referral: _____ Doctor or Nurse Practitioner Referring (print): _____
(yyyy/mm/dd)

Doctor Telephone: _____ Family Health Team (if applicable): _____

Name of child/youth (print): _____ Date of Birth: _____
(yyyy/mm/dd)

Caregiver/Parent: _____ Relationship: _____

Email: _____ Email consent provided: Yes No

OHIP: _____ - _____ Telephone (Home/Mobile/Work): _____

Address: _____

Preferred Method of Contact: Phone Email Other: _____

Is the parent aware this referral has been made? Yes No Is the youth aware? Yes No

Have there been any previous Psychiatric Hospitalizations? Yes No Unknown

Have any medications been trialed for these Mental Health concerns? Yes No

Current Medications

Details of previous Medical or Psychiatric History (Include Family history):

Any previous or current psychiatric/community mental health involvement (please provide as much detail as possible):

Presenting Concern/Reason for Referral (please provide as much detail as possible):

✓ Please advise your patients that appointments are prioritized based on acuity, there is a wait list for services, and we provide assessment and short - term intervention. Your patient may be seen by a Psychiatrist, Resident, Fellow, Allied Health Clinical Team Member or Students/Learners.