TELE-MENTAL HEALTH SERVICES: INFORMATION SHEET

- This referral is for psychiatric consultations via the Tele-Mental Health Services Program, provided by The Hospital for Sick Children, Vanier Children's Mental Wellness and The Children's Hospital of Eastern Ontario (CHEO)
- Case managers must be present during the consultation
- Court-ordered assessments and parenting capacity assessments are not provided
- This service does not provide immediate risk assessment ─ please refer to your local Emergency Department

ELIGIBILITY CRITERIA:

✓ Client must be under 18 years of age
✓ Client resides in a rural, remote and/or underserved area

CHECKLIST:

Please complete all pages of the referral package, as well as include the following, if applicable:
** Mandatory*

- ☐ **Consent Form ***
- ☐ **Case Summary / Assessment ***
- ☐ **Case Manager Contact Details ***
- ☐ Admission History
- ☐ Police Synopsis
- ☐ Discharge Summary
- ☐ Fire Setting Assessment
- ☐ BCFPI
- ☐ CAFAS
- ☐ Risk / Needs Assessment
- ☐ Education Assessment
- ☐ Drug & Alcohol Assessment
- ☐ Psychological Assessment
- ☐ Speech & Language Assessment
- ☐ School
- ☐ Relevant Medical Information
- ☐ Social History
- ☐ Previous Psychiatric Consultation / Other
- ☐ Service Plan / Case Notes
- ☐ Youth Justice Court Documents

SEND TO:

Please direct referrals to the coordinating agency dedicated to serving your community. For more information, visit https://www.sickkids.ca/en/care-services/clinical-departments/telelink-mental-health/ or call Central Intake at **1-877-507-7301** (toll free) or email telepsychiatry.inquiries@sickkids.ca

Tele-Mental Health Services
provided by

SickKids® vanier CHEO

LAST NAME	(FIRST)
MRN	VISIT NUMBER
DATE OF BIRTH DD-MM-YYYY	SEX
ADDRESS	

IMPRINT OR ENTER DETAILS BY HAND

Tele-Mental Health Services
Referral Cover Sheet

CASE MANAGER DETAILS

Name: _____

Name of agency: _____

Email address: _____

Direct phone number: _____ Extension: _____

DATES UNAVAILABLE

Date(s) case manager, client / family is *unavailable* for consultation:

_____

_____

_____

ADDITIONAL INFORMATION

Other relevant information or unique circumstances (i.e., culture, religion, ethnicity, gender preference, lifestyle choices, etc.) and if client is requesting / requires accommodations:

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Tele-Mental Health Services Referral Form

Date of request: _____ Agency client #: _____ MRN: _____
DD - MM - YYYY

Coordinating agency: ☐ AFS ☐ Dilico ☐ HANDS ☐ SOAHAC ☐ Strides ☐ Weechi-it-te-win ☐ Woodview

CLIENT INFORMATION

Patient's name: _____ Preferred name: _____
First, Last

Sex at birth: ☐ M ☐ F Gender: _____ DOB: _____
DD - MM - YYYY

Address: _____ City: _____ Postal code: _____

Health card #: _____ Version: _____ Exp: _____
DD - MM - YYYY

☐ Aboriginal ☐ First Nations ☐ Metis ☐ Inuit ☐ On Reserve ☐ Off Reserve ☐ Other: _____

Language(s) spoken by client: ☐ English ☐ French ☐ Other: _____

Interpretation services required: ☐ Yes ☐ No Language: _____

School grade: _____ ☐ Regular class ☐ Special education ☐ Day treatment ☐ Section 23 ☐ Not attending

GUARDIAN INFORMATION

Guardian name(s): _____

Is legal guardians' address the same as client's? ☐ Yes ☐ No If no, please complete address:

Address: _____ City: _____ Postal code: _____

Language(s) spoken by guardian(s): ☐ English ☐ French ☐ Other: _____

CLIENT / GUARDIAN CONTACT INFORMATION

Name (Client / Parent / Guardian): _____

Email: _____

Telephone #1: _____ Type: _____

Name (Client / Parent / Guardian): _____

Email: _____

Telephone #2: _____ Type: _____

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REFERRING AGENCY INFORMATION

Referring agency: _____ Case Manager: _____

Address: _____ City: _____

Telephone: _____ Ext: _____ Fax (1 per agency / location): _____

Email: _____

PRIMARY CARE PROVIDER INFORMATION (Physician, Paediatrician, Nurse Practitioner, Registered Nurse)

Provider name: _____

Address: _____ City: _____ Postal code: _____

Telephone: _____ Ext: _____ Fax: _____

Is the client currently involved with any other mental health agency or psychiatrist? ☐ No ☐ Yes:

_____

CUSTODIAL STATUS (*Provide legal documentation if available)

☐ Parent relationship intact ☐ Single-parent family

☐ Joint* ☐ Other: _____

☐ Sole custody* _____

RESIDENCE INFORMATION

Resides with: ☐ Bio-Mother ☐ Bio-Father ☐ Stepmother ☐ Stepfather ☐ Same sex parents

☐ Adoptive mother ☐ Adoptive father ☐ Extended family ☐ Independent living

☐ Other (explain): _____

Resides where: (if other than family home)

☐ Foster home ☐ Group home (☐ Short-term ☐ Long-term) ☐ Detention centre ☐ Secure setting ☐ Open

Client before the courts: ☐ Yes ☐ No ☐ Sentenced / YJ **Custody setting:** ☐ Custody / Detention Centre

Treatment program: ☐ Yes ☐ No ☐ Other: _____

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Type of consult requested: ☐ First consultation ☐ Follow-up ☐ Professional-to-professional consultation
☐ Re-assessment *(if the date of the original consult is 2 years or more prior to this request)*

PART A: MAJOR CONCERNS (check all that apply)

☐ Developmental delay ☐ FAE / FAS ☐ Socialization problems

☐ School problems: ☐ Academic ☐ Behavioural ☐ Truancy ☐ Other: _____

☐ ADHD: ☐ Inattentive ☐ Impulsive ☐ Hyperactive

☐ Oppositional defiant

☐ Aggressive behavior: ☐ Verbal ☐ Physical ☐ Other: _____

☐ Antisocial behaviour: ☐ Substance Use ☐ Alcohol ☐ Drug ☐ Fire setting ☐ Other: _____

☐ Conflict with the law [**Specify in Part B**]

☐ Sexual acting out: ☐ Current ☐ Past [**Specify in Part B**]

☐ Mood problems: ☐ Depression ☐ Mood swings ☐ Elevated

☐ Suicidal behaviours: ☐ Current ☐ Past [**Specify in Part B**]

☐ Self-harm – Type (specify): _____

☐ Anxiety ☐ Obsessions ☐ Compulsions ☐ Worry ☐ Avoidant

☐ Somatization

☐ Sleep problems

☐ Eating disorder [**Explain in Part B**]

☐ Family conflict: ☐ Separation from parents / family ☐ Grief

☐ Strange, bizarre behaviour: ☐ Hallucinations ☐ Delusions

☐ Witnessed traumatic events: ☐ Physical ☐ Emotional ☐ Sexual

☐ Experienced trauma: ☐ Physical ☐ Emotional ☐ Sexual

PART B: REASON FOR REFERRAL

Please specify current symptoms, behaviour concerns, etc. Attach additional information if needed:

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MEDICATION INFORMATION

Please list the name(s) and dosage(s) of current / past medications. Include prescription and over-the-counter medications.

Name	Current	Past	Dosage
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

MEDICAL HEALTH HISTORY (Attach additional information if needed)

Indicate any medical problems or allergies*:*

Family history or mental illness (specify and attach additional information if needed):

Mental health history (indicate previous diagnoses or other relevant information):

Current interventions: ☐ None currently ☐ No previous agency involvement

Counselling: ☐ Individual ☐ Family ☐ Parent ☐ Group ☐ Other: _____

Involved in specialized program: _____

Had previous mental health assessments e.g. psychiatric, psychological, TAPP-(C), etc.
Please include previous reports if yes:

☐ No ☐ Yes Date: _____ By whom: _____
DD - MM - YYYY