

## 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*

- |  |  |
|--|--|
| <input type="checkbox"/> <b>Consent Form *</b>                 | <input type="checkbox"/> Education Assessment                      |
| <input type="checkbox"/> <b>Case Summary / Assessment *</b>    | <input type="checkbox"/> Drug & Alcohol Assessment                 |
| <input type="checkbox"/> <b>Case Manager Contact Details *</b> | <input type="checkbox"/> Psychological Assessment                  |
| <input type="checkbox"/> Admission History                     | <input type="checkbox"/> Speech & Language Assessment              |
| <input type="checkbox"/> Police Synopsis                       | <input type="checkbox"/> School                                    |
| <input type="checkbox"/> Discharge Summary                     | <input type="checkbox"/> Relevant Medical Information              |
| <input type="checkbox"/> Fire Setting Assessment               | <input type="checkbox"/> Social History                            |
| <input type="checkbox"/> BCFPI                                 | <input type="checkbox"/> Previous Psychiatric Consultation / Other |
| <input type="checkbox"/> CAFAS                                 | <input type="checkbox"/> Service Plan / Case Notes                 |
| <input type="checkbox"/> Risk / Needs Assessment               | <input type="checkbox"/> 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](mailto:telepsychiatry.inquiries@sickkids.ca)

Tele-Mental Health Services  
provided by



|                                  |              |
|----------------------------------|--------------|
| LAST NAME                        | (FIRST)      |
| MRN                              | VISIT NUMBER |
| DATE OF BIRTH<br>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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## Tele-Mental Health Services Referral Form

### 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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## Tele-Mental Health Services Referral Form

**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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## Tele-Mental Health Services Referral Form

### 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 |
|------|--------------------------|--------------------------|--------|
|      | <input type="checkbox"/> | <input type="checkbox"/> |        |
|      | <input type="checkbox"/> | <input type="checkbox"/> |        |
|      | <input type="checkbox"/> | <input type="checkbox"/> |        |
|      | <input type="checkbox"/> | <input type="checkbox"/> |        |
|      | <input type="checkbox"/> | <input type="checkbox"/> |        |
|      | <input type="checkbox"/> | <input type="checkbox"/> |        |
|      | <input type="checkbox"/> | <input type="checkbox"/> |        |
|      | <input type="checkbox"/> | <input type="checkbox"/> |        |

### 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