# CMHA HKPR OTN PEDIATRIC CLINICAL REFERRAL FORM

Please fax to CMHA HKPR **VIRTUAL CARE PSYCHIATRIC CLINIC**
Attn: OTN Nurse's Jessica Swift / Kara Sicker and Admin Wendy Braund
**PHONE:** 705-748-6687 ext. 1034/1035 **FAX:** 705-748-5649

**Please fill out the whole form or it will be returned to your office (2 pages)**.

**Dr. Charlene Stirling**

Please Note: I am not able to provide urgent assessments. This practice is exclusively OTN.

**REFERRING PHYSICIAN INFORMATION IS REQUIRED**

Referring Physician Name:_____

Prov. Billing #:_____

Address:

_____

_____

Work Phone # / ext:_____ Fax #:_____

Referring Physician is same as (consultant/family physician/other): _____

**PATIENT INFORMATION IS REQUIRED**

Last Name:_____ First Name:_____

Street Address:_____

City:_____ Province:_____ Postal Code:_____

OHIP #_____

DOB: (yy/mm/dd)_____ Age: _____

Sex: (M/F/other): _____

Email address:_____

Contact Preference Name: _____

Relationship to client:_____

Phone #:_____

**APPOINTMENT INFORMATION IS REQUIRED**

Weight: Height: Blood pressure:

Reason for Referral:

_____

_____

_____

_____

_____

**Please attach any relevant clinical notes such as previous consultations, screening forms, growth charts, labs

Medical History:

_____

_____

_____

_____

_____

Current Medications:

_____

_____

_____

_____

Not Eligible for OTN referral if:

1. Actively suicidal
2. Psychosis/Mania
3. Hemodynamically unstable

**Require Signature of Referring Physician / Medical Professional** **DATE:**