

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"/> Consent Form * | <input type="checkbox"/> Education Assessment |
| <input type="checkbox"/> Case Summary / Assessment * | <input type="checkbox"/> Drug & Alcohol Assessment |
| <input type="checkbox"/> Case Manager Contact Details * | <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

Tele-Mental Health Services
provided by



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
	<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