MARKHAM STOUFFVILLE HOSPITAL

Child & Adolescent Services Referral

Fax #: (905) 472-7371

Patient Name:	D.O.B:	☐ Male ☐ Female

Address:	Physician Name:
Patient Email:	Physician Tel #:
OHIP #:	Physician Billing #:

Reason for Referral:

Presenting Problem(s):

- ☐ ADHD
- ☐ Behaviour
- ☐ Anxiety
- ☐ Depression
- ☐ Suicidal Ideation
- ☐ Self-Harm
- ☐ School Refusal
- ☐ Family
- ☐ Other: _____

Potential Adolescent Day Hospital candidate?
☐ Yes ☐ No

Is patient aware of the referral? ☐ Yes ☐ No

Is family aware of the referral? ☐ Yes ☐ No

Mother's Name	Home Phone #	Business Phone #	Cell Phone #
Father's Name	Home Phone #	Business Phone #	Cell Phone #

Significant Medical Illness?

Diagnosis (if known)?

Medications and Dosage

Signature	Date (DD/MM/YY):