ANXIETY TREATMENT & RESEARCH CLINIC
St. Joseph's Healthcare Hamilton – West 5th Site
PEDIATRIC OCD CONSULTATION TEAM – Referral Form

Date of Referral: ☐ / ☐ / ☐

Referring Physician Information

Name of Physician Completing Form: ☐

Please Indicate: Family Physician ☐ Pediatrician ☐ Psychiatrist ☐ Other Specialist ☐

Please specify *Other Specialist:* ☐

Are you apart of a Family Health Team (FHT)? Yes ☐ No ☐

Address: ☐

Tel: ☐ Ext: ☐ Fax: ☐ Billing #: ☐

Patient Information

Patient Name: ☐ Gender: ☐

Date of Birth (dd/mm/yy): ☐ / ☐ / ☐ Age: ☐ HIN #: ☐ VC: ☐

Address: ☐ PC: ☐

Home Phone #: ☐ Day Phone/Cell #: ☐ Ext: ☐

Parent(s) Name(s): ☐

PLEASE SPECIFY Reason for referral:

☐

Please note existence of the following: (Check)

1. Repetitive, intrusive (unwanted and/or unpleasant) thoughts **Yes** ☐ **No** ☐
2. Repetitive behaviors (e.g. cleaning, checking, rereading) **Yes** ☐ **No** ☐
3. Hoarding behaviors **Yes** ☐ **No** ☐
4. Skin picking **Yes** ☐ **No** ☐
5. Hair Pulling **Yes** ☐ **No** ☐
6. Tics: **Motor** ☐ **Vocal** ☐ **None** ☐
7. Was the patient previously diagnosed with:

Autism Spectrum Disorder **If YES** - by Dr. ☐

ADHD **If YES** - by Dr. ☐

Anorexia/Bulimia **If YES** - by Dr. ☐

Developmental delay/CP **If YES** - by Dr. ☐

8. Is the patient acutely suicidal /homicidal? **Yes** ☐ **No** ☐

If YES - P**lease ADDRESS AS AN EMERGENCY (i.e. call COAST, EPT, CAS, etc.)**

9. Is there a history of drug use? **Yes** ☐ **No** ☐

If YES - please specify

10. Has the patient ever made a **suicide attempt?** **Yes** ☐ **No** ☐

If YES - Date:

11. Is there a history of **self-harm?** **Yes** ☐ **No** ☐

If YES – Date:

12. Is the patient currently seeing a psychiatrist? **Yes** ☐ **No** ☐

If YES – Name:

13. Is the patient **currently** taking any prescribed medications? **Yes** ☐ **No** ☐

If YES – List (Name and Dose):

14. Has the patient previously had a psychoeducational assessment? **Yes** ☐ **No** ☐

If YES – Please ADVISE FAMILY TO BRING REPORT TO APPOINTMENT

15. Does the patient have a serious medical condition we should be aware of? **Yes** ☐ **No** ☐

If YES – Note medical condition(s):

Please Fax to the Attention of: Amber Elcock

Fax Number: (905) 521-6120