SAULT AREA HOSPITAL
HÔPITAL DE SAULT-SAINTE-MARIE

DEMOGRAPHIC LABEL

Sault Area Hospital Mental Health and Addictions Services
Child and Adolescent Psychiatric Consultation Clinic (CAPCC) Referral Form

The consultation process functions within a shared-care model and will involve an initial meeting with the CAPCC Consultation Team. Recommendations for care will be provided to the patient and the referring primary care provider. **Referrals are only accepted from a psychiatrist who has seen a child or youth in the SAH Child/Adolescent inpatient unit or the SAH Emergency Department.**

Referrals for the exclusive purpose of legal, insurance or worker's compensation issues will not be accepted. Please confirm that this is not a referral for such a consultation. Confirmed : ☐Yes ☐No

Identifying Information for Referral: **Age Requirement (8 – 17yrs)**

Last Name: _____ **First Name:** _____

Address: _____

DOB: _____ **OHIP #** _____

Phone #: _____ **Parent/Guardian:** _____

Notes about who to contact: _____

Client is involved with Algoma Family Services: ☐Yes (name)_____ ☐No ☐Unknown

Is the person aware of this referral? ☐Yes ☐No

History of Violence: ☐Yes ☐No

Has the person being referred received previous psychiatric consultation ☐No ☐ Yes – with who:

_____

Preliminary Concerns (check all that apply)

☐Mood Disorders ☐OCD or related disorders (hoarding) ☐Substance Use Disorders

☐Anxiety Disorders ☐PTSD ☐Psychotic Disorders

☐Eating Disorders ☐Other (please specify)_____

Reason for Referral:☐ (Please attach Referral Letter/Summary and all relevant notes)

☐Diagnosis ☐Psychopharmacology recommendations ☐2nd opinion

☐Recommendation for treatment plan

Comments:_____

_____

Name of Referring Psychiatrist: _____

Contact #:_____ **Date of Referral:** _____

To confirm your commitment to the Shared Care Model please check: ☐Yes

(Please note if this is not checked off it will delay the referral)

Please Fax Referrals to : 705-256-3494 **For Referral Status call: 705-759-3434 ext 4603**