Physician Referral Form-Peel Region

For children and youth under the age of 18

Information on the Child/Youth

Child/Youth First Name: ______________________ **Last Name:** ______________________

Date of Birth: ________ ________ ________ (*Day* *Month* *Year*) **Gender:** Male ☐ Female ☐ Other ☐:______________

Health Card No.: ______________________ **Version Code:** ________ **Exp. Date:** ____________

Address: ________ ______________ ______________ ON ____________
Apt./Unit # *Street* *City/Town* *Province* *Postal Code*

Child/Youth lives with: Both parents ☐ Mother ☐ Father ☐ Other ☐:______________________

Who should be contacted for this referral?

Child/Youth: Yes ☐ No ☐ **If no, who?:** ______________ **Relationship to Child/Youth:** ____________

Phone No.: ______________________ **Can messages be left?** Yes ☐ No ☐

Reason for Referral *(please print clearly and check all that apply)***:**

Seeking a psychiatric consultation ☐ Seeking a diagnostic assessment ☐ Seeking mental health counseling/treatment ☐

Seeking a medication review ☐ Seeking a second opinion ☐

Other (specify): ☐

<u>**Required Physician Information**</u>

Physician Name:
Physician Address:
Physician Phone No.:
Physician Fax No.:
Billing No.:

Physician Office Stamp, if applicable:

Date of Referral: ________ ________ ________ (*Day* *Month* *Year*) ______________________ ***Physician Signature***

FAX completed form to (905) 696-0352
WhereToStart.ca Phone No.: (905) 451-4655