Champlain LHIN

Mental Health and Addictions Nurse Program

Referral Form

Ontario

The Champlain LHIN's Mental Health and Addictions program aims to support children and youth in schools that may have mild to complex mental health and/or substance abuse issues. The LHIN goals are to support the individual to thrive, remain or successfully transition back to school

Client Information *Items with * are mandatory fields and referral will not be processed if information is not provided.*			
Client Name * :		Gender:*	☐ Male ☐ Female ☐ Other
Home Address: *		City:*	
		Postal Code:*	
Phone # : *		Date of Birth: *	
HCN:		VC:	
School Name : *		School Board :	
Grade:		Preferred Language : *	☐ English ☐ French ☐ Other
Diagnosis:		Prescribed Medication:	
Allergies :			
Parent/Guardian Contact Information			
Primary			
Name:		Role:	☐ Mother ☐ Father ☐ Guardian
		Home Phone:	
Address:		Cell Phone:	
		Business Phone :	
		Email :	
Secondary			
Name:		Role:	☐ Mother ☐ Father ☐ Guardian
		Home Phone:	
Address:		Cell Phone:	
		Business phone :	
		Email :	

Reason for the Referral			
☐ Anxiety	☐ Symptoms of Depression	☐ Drug/Alcohol Abuse	☐ Eating Disorder
☐ Recent Loss	☐ Risk to Others	☐ Risk to Self	☐ Other *(Describe below)*
	☐ Agression	☐ Suicide attempt If yes, when?:	
Additional or (Please provide additional details if you checked any boxes) :			

Consent

4200, rue Labelle Ottawa (Ontario) K1J 1J8

Telephone : *613 745-5525* | ***Toll Free :*** *1 800 538-0520* | ***Fax :*** *613 745-1093* | ***Toll free fax :*** *1 888 990-8151*

http://healthcareathome.ca/champlain/en

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I hereby agree with the information contained above and consent to this referral being shared with a Mental Health and Addiction Nurse and the Champlain Community Care Access Centre :	
Verbal Consent for Referral Obtained from the Student: *If competent (regardless of age) student consent must be obtained.**	☐ Yes ☐ No
Consent for Referral Obtained from the Parent/Guardian: *(if required by school board)*	☐ Yes ☐ No ☐ N/A

Attachments			
Healthcare Professional Use Only			
☐ Medical, Social Work or Psychiatric History	☐ Medications List	☐ Recent Lab Results	☐ Discharge Summary
☐ Other (Describe):			

Referral Made by			
Name:		Title:	
Referral Source (School/ Self-Referral/ Hospital/ Physician/etc.):		Phone #:	
		Fax #:	
Signature:		Date :	

Please fax this referral form together with additional documents to the Champlain LHIN at : **1 888 990-8151**
A Champlain LHIN Mental Health and Addictions Nurse will contact the individual or parent/guardian to confirm informed consent for services.