MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

Child & Youth Extensive Needs Service Program Referral Form

REF

Phone: (416) 469-6580 Ext. 3144

Fax: (416) 469-6179

Patient Label

This is a referral to the Extensive Needs Service at MGH. Upon acceptance of referral, the family will be contacted for an intake assessment.

The referring provider will be contacted if the referral is NOT accepted.

Referral Date (DD/MM/YYYY) _____/ _____/_____

Client Information			
Last Name:	First Name:		Date of Birth: (DD/MM/YYYY)
Preferred Name:		Preferred Pronoun/s:	Age:
Address:		Apt #:	
Town or City:	Province:	Postal Code:	
Health Card Number:	Version:	Expiry Date:	
MRN (if known):			
Gender: ☐ Female ☐ Trans-Woman ☐ Two-Spirit ☐ Gender fluid ☐ Androgynous ☐ Male ☐ Trans-Man ☐ Non-binary ☐ Genderqueer ☐ Other:			
Language(s) Spoken:		Preferred language:	
Interpreter Required: ☐ Yes ☐ No If yes, specify language:		Accessibility Concerns: ☐ Yes ☐ No If yes, specify concern:	
Is the family aware about this referral: ☐ Yes ☐ No			
Communication Method: (Please check all that apply)			
Contact Number: Is contact number. a cell phone number ☐ Yes ☐ No		Email Address:	
Consent Signed For: Voice Mail ☐ Email ☐		Has internet access for Video Visits: ☐ Yes ☐ No	
Patient's communication preference for appointment reminder: Voice call ☐ Email ☐ Text ☐			
Emergency Contact Information			
Name:	Phone:		Relationship:
Is consent provided to contact the above person in case of an emergency? ☐ Yes ☐ No			

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Which ethinicity best describes the client you are referring:	
☐ Black	Eg. African, Afro-Caribbean, African Canadian descent
☐ East/Southeast Asian	Eg. Chinese, Korean, Japanese, Taiwanese descent or Filipino, Vietnamese, Cambodian, Thai, Indonesian, other Southeast Asian
☐ Indigenous (First Nations, Métis, Inuk/Inuit)	Eg. First Nations, Métis, Inuk/Inuit descent
☐ Latino	Eg. Latin American, Hispanic descent
☐ Middle Eastern	Eg. Arab, Persian, West Asian descent (Afghan, Egyptian, Iranian, Lebanese, Turkish, Kurdish)
☐ South Asian	Eg. South Asian descent (East Indian, Pakistani, Bangladeshi, Sri Lankan, Indo-Caribbean)
☐ White	Eg. European descent
☐ Another race category	Includes values not described above
☐ Do not know	Not applicable
☐ Prefer not to answer	Not applicable

Referring Source			
Last Name:	First Name:		
Title/ Position:			
Address:	City:	Province:	Postal Code:
Date of Referral (MM/DD/YYYY):	Phone:	Fax:	

Reason for referral

Client / Staff Safety Concerns

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Select relevant Diagnoses for this Client:

☐ Acquired Brain Injury ☐ ADHD ☐ Autism
☐ Communication Disorder ☐ Global Development Delay ☐ Intellectual Delay
☐ Learning Disorder

Select any relevant Mental Health Conditions:

☐ Anxiety ☐ OCD ☐ Mood Disturbance
☐ Psychosis ☐ Addiction ☐ Attachment / Trauma
☐ Somatic Symptoms ☐ Chronic Irritability

Select any Medical conditions for this Client:

☐ Cerebral Palsy ☐ Epilepsy ☐ Heart Disease
☐ Sleep Disturbance ☐ ARFID

Does the client have any Medication/Polypharmacy needs:

☐ Multiple psychiatric medications ☐ Psychiatric medication side effects
☐ Diagnostic complexity impacting medication choices ☐ Failed behavior medications for longer than a year
☐ Other:_____

Identify the behaviours of concerns:

☐ Aggression ☐ Hyperactivity ☐ Impulsivity
☐ OCD-like behaviour ☐ Anxiety ☐ Self-Injury
☐ Irritability ☐ School Avoidance

Have there been challenging behaviours present for over 12 months, or significantly escalating for over 6 months: ☐ Yes ☐ No
Please describe:

Please list any agency involvement and therapy provided over the past 12 months:

Are the needs of the client/family unmet with present services: ☐ Yes ☐ No
Please describe:

Are there family/caregiver complexities present: ☐ Yes ☐ No
Please describe:

What services are most needed for this client?

Is there anything else you would like the team to know?