CPRI
CHILD & PARENT RESOURCE INSTITUTE

Ontario

Referral for Tertiary Medical Consultation Pilot Service

This pilot service offers a one-time consultation with a CPRI Paediatrician for a developmental-behavioural assessment, or Child & Adolescent Psychiatrist, which may also include an indirect Psychopharmacological specialist consultation. Psychopharmacology is a specialized field that analyzes the impact of different drugs on the mental health of patients, ensuring that the right medication is delivered in the right format at the right dose for the right condition. The child and family will be asked to attend the appointment. Referrals will only be accepted by a medical specialist (ie. Paediatrician, Psychiatrist, Neurologist, Geneticist, etc). All recommendations are provided back to the referring specialist. **If further CPRI services are required, a new referral full Intake package must be completed.**

REFER TO: (check one)

- ☐ Developmental Paediatrics
- ☐ Developmental Paediatrics plus Psychopharmacology consult
- ☐ Child & Adolescent Psychiatry
- ☐ Child & Adolescent Psychiatry plus Psychopharmacology consult
- ☐ Psychopharmacology consult only (child and family will not be seen)

REQUIRED: Referent Question or Concern to be addressed (*please be specific*):

Your own recent consultation report and consent to the disclosure, transmittal or examination of a clinical record (see page 3, 4) is **required.** Also, please provide the most recent assessments completed on child, i.e., genetics, neurology, psychology, developmental, social work, etc.

☒ Referent's recent consultation report ☒ Consent completed (see pages 3,4)
☐ Other (1): _____ ☐ Other (2): _____
☐ Other (3): _____ ☐ Other (4): _____

Client Name: _____ D.O.B.: _____

Client Current Address: _____ City: _____

Postal Code: _____ Telephone: _____

Health Card Number: _____ Version Code: _____ Expiry Date: _____

Custody currently with: ☐ Parents ☐ Father ☐ Mother ☐ Legal Guardian(s):

☐ Other (please specify)

Past involvement with CPRI: ☐ Yes ☐ No

Functional Level: ☐ Not Yet Determined ☐ Developmental Delay ☐ Average Range
☐ Gifted ☐ Intellectual/Developmental Disability

Confirmed Diagnosis:_____

Provisional Diagnosis:_____

List Current Services/Supports:_____

Current/Past Medication Chart: (attach list if you need more space)

Current Medication	Dose	Date Started	Date Stopped	Side Effects Noted	Concerns
Past Medication	Dose	Date Started	Date Stopped	Side Effects Noted	Concerns

Date: _____ Specialty Physician: _____ Signature: _____

Billing #: _____ Email: _____ Fax: _____

Note: To help better serve your clients needs we will be sending you a link to an online survey for your feedback on the Tertiary Medical Consultation Service Pilot. Please provide your e-mail address above or identify how we may best contact you for your feedback.

PLEASE ENSURE YOU COMPLETE ALL PAGES OF THIS FORM.

Completed packages or questions can be emailed to: CPRI.Intake@ontario.ca

Fax (519) 858-2115

Ministry of Children, Community and Social Services

Service Delivery Division
CPRI
600 Sanatorium Road
London ON N6H 3W7
Tel: (519) 858-2774
Fax: (519) 858-3913
TTY: (519) 858-0257

Ministère des Services à l'enfance et des services sociaux et communautaires

Division de la prestation des services
CPRI
600 Chemin Sanatorium
London ON N6H 3W7
Tel: (519) 858-2774
Téléc.: (519) 858-3913
ATME: (519) 858-0257

Ontario

CB# _____

CONSENT TO THE DISCLOSURE, TRANSMITTAL OR EXAMINATION OF A CLINICAL RECORD

I,_____,_____, of _____
hereby authorize CPRI to examine/obtain from, transmit or disclose to:
(Include Full name/address of agency/school/physician)

_____ _____
_____ _____
_____ _____

the following: (check appropriate item(s))

☐ Educational Records

☐ Clinical Records

in respect of _____for the purpose of: Assessment, Treatment and Planning

Description of information to be examined/transmitted/disclosed:

☐ Any pertinent information

☐ Specifically:_____

Please note that this information may be released electronically, which includes by fax.

Unless otherwise stated, **this consent is valid for the length of time the child is receiving CPRI services and 1 year after all CPRI services are completed** (CPRI discharge) to allow:

- CPRI to assist you in your transition to other services as needed and/or,
- CPRI services to be re-activated within 1 year after your discharge when needed.

I understand that I may revoke this consent in writing at any time.

This consent for examination, transmittal or disclosure of information has been fully explained to me. I understand it and agree with the examination, transmittal or disclosure.

Child/Youth Signature _____Date _____

And/Or ☐ Consent of substitute decision-maker is required.

Guardian/Substitute Decision-Maker Signature Date _____

_____

GUIDELINES FOR COMPLETION OF CONSENT TO THE DISCLOSURE, TRANSMITTAL OR EXAMINATION OF A CLINICAL RECORD FORM

1. Please specify if you wish to DISCLOSE or OBTAIN information.

2. To DISCLOSE information:

   - list as many agencies, facilities, physicians, pediatricians, etc. that are involved with the child/youth's care
   - be sure to include the complete mailing address, if available
   - reports will not automatically be sent unless specified by a verbal or written request from CPRI clinicians
   - dictated reports that have carbon copies (c.c.) will be mailed out by Clinical Records staff
   - CPRI requires a consent with an ORIGINAL SIGNATURE in order to release information

3. To OBTAIN information:
   - use a separate consent form for each request as agencies, facilities, physicians, pediatricians, etc. require an ORIGINAL consent
   - for ease in processing, we are using a separate consent to obtain/disclose information from/to school boards/schools
   - when requesting a child's birth record, it is helpful to include the mother's surname (if different than the child's or if different at the time of the birth) and mother's date of birth

*****IF YOU HAVE ANY QUESTIONS CONCERNING THE ABOVE, PLEASE CONTACT EXTENSION 2024*****