Waypoint
CENTRE for MENTAL HEALTH CARE
CENTRE de SOINS de SANTÉ MENTALE

500 Church Street, Penetanguishene ON L9M 1G3
500, rue Church, Penetanguishene (Ontario) L9M 1G3
705-549-3181 www.waypointcentre.ca

Waypoint Centre for Mental Health Care Referral

Family, Child, and Youth Mental Health Program

If you have any questions about the referral process, please call Waypoint Centre for Mental Health Care's Central Intake department at **705-549-3181 ext. 2308**.

Visit our website for a list of services, programs, and criteria.

Program Description

Waypoint's Family, Child, and Youth Mental Health Program offers consultation services for children and youth with mental health and behavioural concerns within the Simcoe/Muskoka/Parry Sound Region. Typical concerns include autism, developmental delays, mood disorders, anxiety, behavioural concerns associated with childhood trauma, disruptive behaviours, and school concerns. Clients are seen in consultation by a Physician for diagnostic and treatment purposes. Recommendations will be provided to the primary care practitioner requesting the consultation. Specific treatment, if indicated, may be initiated and follow-up visits may be offered when required and in collaboration with the client's health care team. Service can be provided in-person or virtually. In most cases, it is expected that caregiver(s) attend the appointment with the client.

Referral Requirements

- A clear description of the behavioural/mental health concerns and completion of the referral form.
- A summary of (or copies of) previous relevant consultations, allied health reports, and school reports.
- If relevant, details of parental custody and a copy of legal documentation.

Inclusion Criteria

- Must be 17 years of age or under.
- Child and youth must be a willing participant in the consultation.
- Agreement with the expectation that care will be provided collaboratively with therapists and primary care providers.

Exclusion Criteria

- Requests for court ordered assessments, parenting assessments, and insurance assessments will not be considered.
- Medical conditions that are better assessed and treated by a general paediatrician or other subspecialist paediatrician.
- Emergent or urgent concerns that are best addressed in an Emergency Department (e.g., active suicidality, serious self-harm, etc.).
- Learning issues that are better assessed by a psychologist (e.g., educational assessments for learning disabilities).
- Requests for second opinions, or clients already in the care of a pediatrician or child and adolescent psychiatrist. Please consider Sick Kids telemedicine or OTN e-consult.
- If the client is outside of the Targeted Service area. Please refer to our website to view a map that displays these details.

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Considerations
• If concerns include medical issues associated with the mental health or behavioural or developmental concerns, we may recommend that the client also be referred to a general pediatrician. • If this referral is for the assessment of an eating disorder, please note that the Family, Child and Youth Mental Health Program is focused on the mental health component of eating disorders. For assessment of medical concerns or medical stability related to eating disorders, please refer to Pediatrics at Orillia Soldiers' Memorial Hospital (OSMH) or Royal Victoria Regional Health Centre (RVH) or the Eating Disorders Clinic at either of these locations.
Admission and Discharge Planning
• Not applicable

***Please send the completed Referral Form and attach any relevant allied health reports, school reports, or consultation reports, as well as a current custody agreement (if applicable).**

***Please be advised that we will only use the primary contact telephone number to schedule appointments and to provide information.**

FAX COMPLETED FORM AND ACCOMPANYING DOCUMENTATION TO:
Waypoint Centre for Mental Health Care Central Intake by fax to 705-549-1812 or by email to centralintake@waypointcentre.ca.

We cannot begin processing the referral without a completed Referral Form and the supporting documentation.

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Waypoint Family, Child, and Youth Mental Health Program Referral

FOR WAYPOINT USE ONLY	Date Received:		Account #:	

Client/Patient Information

Name of Child (Last name, first name):			
DOB *(dd/mm/yyyy)*:		Preferred Name:	
Gender:	☐ Female ☐ Trans (male to female) ☐ Intersex ☐ Two Spirit		
	☐ Male ☐ Trans (female to male) ☐ Other (please specify):		
Health Card Number:		Version Code:	
Does the patient/client self-identify as:	☐ First Nations ☐ Inuit ☐ Métis ☐ Urban Indigenous		
Parent/Guardian Name:		Relationship to Child:	
Is there a Custody Agreement in place?	☐ No ☐ Yes (include a copy with this referral, if available)		
Address:		City:	Postal Code:
Primary Telephone #:		Alternate Phone #:	
Parent/Guardian Email Address:			
Interpreter required?	☐ Yes Language:		
☐ **Urgent Clinic (Discussed with On-Call Physician)**			

Referral Source Information

Referring Physician:		Billing #:	
Telephone #:		Fax #:	
Associated Family Health Team (FHT)/Partner *(Please note: this information is for data analysis purposes only)*:	☐ Algonquin FHT ☐ Cottage Country FHT ☐ HANDS		
	☐ Georgian Bay FHT ☐ Parry Sound FHT ☐ None		
	☐ Mamaway ☐ Children's Treatment Network		
	☐ North Simcoe FHT ☐ Other (please specify):		
If referral is not completed by primary care provider, please complete the fields below.			
Primary Care Provider Name & Billing #:		Aware of referral? ☐ Yes ☐ No	
Telephone #:		Fax #:	
Referral Completed By:		Contact #:	
I understand and agree to participate in the Shared Care model of care for this patient.		**Signature:**	

Your submission of this referral form will be taken to explicitly mean that you have obtained appropriate permissions for releasing the information contained in this referral form to Waypoint Centre for Mental Health Care (the agencies) and Services to whom you are submitting this referral form. If applicable, please include your Organization's Consent to Release of Personal Health Information Form.

Referral Information

Reason for Referral and Presenting Concern: What is the reason for this referral? What clinical question would you like to have answered?

**Note:* If this referral is for assessment of an eating disorder, please note that the Family, Child, and Youth Mental Health Program at Waypoint is focused on the mental health of eating disorders. For assessment of medical concerns or medical stability related to eating disorders, please refer to Pediatrics at OSMH or RVH or the Eating Disorders Clinic at either of these locations.

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Additional Information (Relevant medical history, family history, social history):

Previous Treatment: What treatment, including therapy or medication, has been trialed already to address the presenting concern? If none, please provide rationale.

Other Referrals: Has this client been assessed and/or been referred to be assessed (virtually or in person) by any other clinician for this presenting concern within the past year?

**Note:* Requests for second opinions or referral for clients already in the care of a pediatrician or child and adolescent psychiatrist cannot be supported by the Family, Child, and Youth Mental Health Program. Please consider Sick Kids telemedicine or OTN e-consult.

Medication List

Include prescription, vitamins, over the counter medications, and herbal supplements

Medication	Dose/Units	Route	Frequency	Instructions/Comments
☐ See attached Medication List/copy of Medication Administration Record