camh IMPACT
Individualized Medicine: Pharmacogenetic Assessment & Clinical Treatment

Send to: The IMPACT Team
Centre for Addiction and Mental Health (CAMH)
250 College Street
Toronto, ON M5T 1R8
Phone: 416-535-8501 ext. 30240
Fax: 416-979-4666
Email: impact@camh.ca

IMPACT STUDY REFERRAL – CHILD & ADOLESCENT (AGE 7 TO 15)

Please Note the Following Information:

Please print clearly and ensure contact information is correct. We will contact the family to set up the appointment.

Date of referral: _____/_____/_____
dd mm yyyy

CHILD/ADOLESCENT INFORMATION

Legal Name:___________________________________
(LAST NAME, FIRST NAME)

Preferred Name *(if applicable)*:________________________

Date of Birth: __________________ Age:_______________
(dd/mm/yyyy)

Sex/Gender: Female Male

Academic Grade: School Placement:_______________

OHIP Registration #:__________________________________

GUARDIAN INFORMATION

1. Guardian Name:____________________________________

Relationship to Child:_________________________________

Home Telephone:____________________________________

Mobile:____

Email:____

Can a confidential phone or email message be left?
YES NO

2. Guardian Name:____________________________________

Relationship to Child:_________________________________

Home Telephone:____________________________________

Mobile:____

Email:____

Can a confidential phone or email message be left?
YES NO

REFERRING SOURCE INFORMATION

Name:______________________________
(LAST NAME, FIRST NAME)

Circle One: Child Psychiatrist
Psychiatrist
Family Physician
Nurse Practitioner
Other:______________________

CPSO ________________ OR

Medical License #:_______________

Telephone:_____________________________________
Fax:____
Email:_______________________________________

Address:_____________________________________
____
____

Please answer the following questions: (circle one)

1. Does the referring source wish to receive a consultation report? YES NO

2. Is your client aware of the referral and that he/she will be seen?
YES
NO *(Please explain)*:_____________________

3. Are there any barriers to communication and/or accessibility with this client/patient?

YES *(please explain & specify specific communication disorder):*
____
____

NO

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IMPACT RESEARCH STUDY REFERRAL – CHILD & ADOLESCENT (AGE 7 TO 15)

CLIENT/PATIENT NAME: ___________________________
Last Name, First Name

1. CURRENT Working Diagnosis/Clinical Problem(s) (circle all that apply)

WORKING DIAGNOSIS (circle all that apply)	SPECIFY CURENT CLINICAL PROBLEMS	RELEVANT HISTORY
Specific Learning Disorder	Reading Written Expression Mathematics	
ADHD	Inattentive Hyperactivity/impulsivity Combined	
Anxiety	Social Panic OCD Generalized Separation PTSD Phobias	
Depression	Hallucinations Delusions	
Bipolar	Type 1 Type 2	
ASD	Please Specify:	
Psychotic Disorders	Please Specify:	

2. RISK ISSUES

RISK ISSUES	CHECK IF ***YES***	DATE(S)	DETAILS
Suicide attempt/ideation			
Self-harming behaviours			
Violent behaviour			
Behavioural concerns			
Social concerns			
Substance/Addiction issues			

3. CURRENT MEDICATIONS (Psychiatric) (*attach additional information if needed)*

MEDICATION	DOSE/FREQUENCY	RESPONSE & ADVERSE AFFECTS

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IMPACT RESEARCH STUDY REFERRAL – CHILD & ADOLESCENT (AGE 7 TO 15)

CLIENT/PATIENT NAME: ________________________
Last Name, First Name

4. PAST MEDICATIONS (Psychiatric) (*attach additional information if needed)*

MEDICATION	DOSE/FREQUENCY	RESPONSE & ADVERSE AFFECTS

5. PAST PSYCHIATRIC HOSPITALIZATION

FACILITY	DATES (dd/mm/yyyy)	REASON

6. PROPOSED TREATMENT (FOR REFERRING CLINICIAN TO COMPLETE):

Imagine that you had not ordered pharmacogenetic testing for this patient. How would you have proceeded with their treatment (e.g. maintain current therapy, augment, switch, titrate off, initiate psychotherapy, etc.)? If additional medications, which medication and why?

RELEVANT MEDICAL HISTORY

ADDITIONAL INFORMATION RELEVANT TO THE RESEARCH STUDY

Completed by:

___________________________________ ____________________ ______________
(Print name and Credentials) (Signature) (dd/mm/yyyy)