

****All Sections Must Be Complete**

REFERRAL FORM

Dr. Kenneth Handelman
Child & Adolescent Psychiatrist

Department of Psychiatry William Osler Health Centre - BMHC
20 Lynch Street, Brampton
Ontario L6W 2Z8

(Tel) (905) 451-1710 ext. 25737

(Fax) (905) 796-4158

Patient Name: _____

Date of Birth: _____ **Age:** _____

Address: _____

Phone#: _____ **Cell/Other:** _____

OHI#: _____ **Version Code:** _____

NEW REFERRAL: _____ **REPEAT CONSULTATION:** _____

REFERRING PHYSICIAN'S NAME: _____

Phone#: _____ **Fax:** _____ **PHYSICIAN#:** _____

Reason for Referral:

Previous Psychiatric Care:

Medications:

*please append more information if necessary

PLEASE NOTE:

A) FOR A REFERRAL TO BE ACCEPTED, THE PATIENT MUST MEET THE FOLLOWING CRITERIA:

- 1) **16 years of age or younger** at the time of referral
- 2) **Geographic catchment** – Only service patients who live in the Peel Region, Dufferin Region or Etobicoke (area of Osler). If patient lives in another region – i.e. Halton (Georgetown), Vaughan (Woodbridge), etc – The referral will be refused; and it may take 1-3 months from my office to get back to you personally about it.
- 3) Occasionally, referrals will be accepted to **assess adults for ADHD**. These slots are limited as my main focus is Child & Adolescent Psychiatry. My office will respond in 1-3 months if I can take the referral.

B) Service Provided: Due to excessive patient care loads, Dr. Handelman is able to provide **psychiatric consultation only** and not ongoing care. If a patient may need counselling, please **have them self refer** to one of the following: Peel Children's Centre: 905-451-4655 Report Youth: 905-455-4100 Family Services of Peel: 905-453-5775 Catholic Family Services: 905-450-1608 (Brampton) 905-897-1644 (Mississauga)
Or visit: www.DrHandelman.com for this list online.

C) If the patient was previously seen by Dr. Handelman, please indicate **REPEAT CONSULTATION**, and efforts will be made to accommodate the patient more quickly.

D) If any elements of the referral are missing – i.e. Dr. Referring#, signature, patient address, etc., the referral will be refused, though it may take 1-3 months from my office to respond personally.

E) If this is a referral to GAD Hospital Program, please complete a GAD referral and send to: Fax#: 905-796-4122.

F) Legal Court Custody Assessments: Medical legal, custody and access and so called "court ordered" assessments are not provided.

Referring Doctor's Signature: _____ **Date:** _____

This form is available online at www.DrHandelman.com

As of November 1, 2006, referrals must be submitted on this form to be accepted