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REFERRAL FORM

Referring Provider: _____ **MSP #:**_____
Profession: _____ **Clinic Name:** _____
Phone #: _____ **Fax #:**_____**Email:** _____

☐ Referring provider agrees to provide follow up care, and prescribe refills for recommended medications as appropriate.

Patient Name: _____**Preferred Name:** _____**Pronouns:** _____
DOB: _____ **PHN:**_____ **Best phone number:**_(_____)_____-_____
Address: _____ **City:** _____ **Province:**

*****Patient Email:** _____ **MUST BE INCLUDED!**

REASON FOR REFERRAL

MSP Covered:

☐ **Physician assessment only**

☐ **Physician assessment and initial treatment if needed (*up to 3 months*)**

If you would like us to initiate medication please complete a physical exam within 6 months of referral for:

BP _____/_____
Pulse _____ BPM
CVS Exam ○ normal exam, no arrythmia present on auscultation
Thyroid ○ palpates normal

Self pay: *Self-pay but we can provide letters of support for extended health benefits or employer coverage.* ***Checking either box here means we will send your patient some information about these options.***

☐ **ADHD Group Course: Level Up your ADHD Game**
8 week virtual group course run by our Physician and Occupational Therapist that provides strategies for improving executive function (working memory, time management, organization, self-regulation and impulse control).

☐ **Individual sessions with our Occupational Therapist**
Practical strategies to improve executive functioning through DBT, education and coaching.

PATIENT HISTORY

Positive psychiatric history (please provide details):

Relevant medical history (seizures, traumatic brain injury):

Current medications:

PROCESS

1. *Send referral for assessment/management/or psychoeducational course*
2. *We will contact patient to offer some intake forms to complete.*
3. *Once intake forms are completed patient will be sent an appointment date.*
4. *Over 2-3 sessions patient will be assessed for ADHD and other common mental health co-morbidities.*
5. *If you've elected for management, we will start patient on appropriate treatment.*
6. *Patient will be discharged back to your care after assessment or after 3 months of management (if this was requested).*
7. *We'll send a consult note once patient has been discharged.*
8. *You'll have the ability to follow up with one of our physicians as needed if you have questions about pharmacological management.*

Date: _____ **Provider Signature:** **Or Tick for electronic signature:** ☐

Thank you for entrusting us with the care of your patient.

- Our aim is to provide comprehensive assessment for ADHD and full scope treatment options.
- We endeavour to provide a thorough assessment for ADHD along with other commonly found mental health co-morbidities e.g. generalized anxiety disorder, OCD, mood disorders, PTSD and substance use disorder.
- We offer to initiate treatment as we know many providers find initiation of ADHD treatment to be challenging in a primary care setting. This will allow us to make appropriate adjustments to medications/dosages to help minimize ADHD symptoms for your patient during their assessment period.
- We also feel strongly that pharmacological treatment should go hand in hand with a solid understanding of what ADHD is, and an individualized approach to creating strategies to help your patients minimize ADHD symptoms to live, work, parent and participate in their world at their full potential. We provide a self-pay course, but will also provide excellent resources for those who cannot afford/prefer not to take our course to learn about behavioural approaches to managing ADHD. We also offer self-pay one-on-one sessions with our Occupational Therapist.
- We are primary care providers ourselves, and we want to continue to collaborate with you if you have any questions or want support if medications need to be adjusted.

For more information about our website please visit: LevelUpADHD.ca

Level Up ADHD