

Once completed, please fax to 519-787-0773 or email with a password to
info@launchbh.ca

Patient Information

First name: _____

Last name: _____

Date of birth (MM/DD/YYYY): _____

Sex: Male Female

Patient Address:

Address: _____ Unit: _____

City: _____ Province: _____ Postal Code: _____

Patient or Delegate Contact Information:

Contact information is for: Patient Delegate (if delegate, specify name and relationship to patient):

Telephone: _____

Can we leave a voicemail? Yes No

Email: _____

Can we contact by email? Yes No

Is the patient/patient's parents or guardians aware of referral?

Yes No

Custody Status (for youth under age 16)

Joint Custody (Please fill out contact information for both guardians)

Sole Custody (Please fill out contact information for the sole guardian)

Lives with both parents/ Married/ Common Law (Please fill out contact information for both guardians)

Other (e.g. CAS), please specify: _____

1. Guardian Name: _____

Telephone: _____

2. Guardian Name: _____

Telephone: _____

Reason for Referral

Please indicate primary reason for referral (specify current symptoms, presenting problems and history):

Learning/Attention Behavioural/Emotional Regulation Stress/Anxiety
Mood/Depression Social Difficulties Other (elaborate below)

Please specify service focus (select all that apply):

Psychological Assessment Mental Health Services Applied Behaviour Analysis (ABA) Services
Executive Function/Attention Deficit Hyperactivity Disorder (ADHD) Services Parent Coaching
Social Skills Groups Mental Health Groups

Risks and Safety Concerns

Please share any concerns relating to suicide attempts/ideation, self-harm, aggressive or disruptive behaviour, legal involvement, other safety concerns:

Service Location

Toronto Fergus Owen Sound Virtual

Referring Provider Information

Family Physician Nurse Practitioner Pediatrician Psychiatrist Other , please specify:

First name: _____

Last name: _____

Referring Provider Address:

Address: _____ Unit: _____

City: _____ Province: _____ Postal Code: _____

Telephone: _____ Fax: _____ Email: _____

Follow-Up

Please indicate if you would like to receive follow-up communication regarding this referral: Yes No