CYAN CLINIC
COMPLEX YOUTH ADHD NANAIMO

Complex Youth ADHD Nanaimo Clinic Referral Form

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Oceanview Paediatrics
Collaborative Care

Date of Referral: _____
Referring MD/NP: _____
Contact number: _____

PATIENT IDENTIFICATION INFORMATION:

Patient Name: Date of Birth: Address: Home Phone: Cell Phone:	Gender: PHN: E-Mail:	School: Grade:

PARENT AND/OR GUARDIAN CONTACT INFORMATION:

Legal Guardian: Relationship: Home Phone: Cell Phone: Work Phone: E-Mail:	Parent/Caregivers: (if different than guardian) Relationship: Home Phone: Cell Phone: Work Phone: E-Mail:

REASON FOR REFERRAL:

Meets the following CYAN Clinic referral criteria (check all that apply. If none apply, send referral to Dr. Michelle Francis for review):

- ☐ Suspected ADHD in a child with pre-existing developmental/mental health comorbidities
- ☐ Suspected neurodevelopmental disorder in child with diagnosed ADHD
- ☐ Family barriers to ADHD management
- ☐ School barriers to ADHD management
- ☐ ADHD treatment failure/resistance

Medical/Developmental/Psychiatric Diagnoses (when diagnosed & by whom):

Medications prescribed (indicate dosage, duration, and any positive or negative effects):

Specific Desired Outcome:

Family Physician, Paediatrician, or other Professionals Involved:

RELEVANT CLINICAL DOCUMENTATION:

- ☐ I have forwarded all assessment reports, relevant notes, and lab results on file
- ☐ I have directed the caregivers to www.oceanviewpaediatrics.com/CYAN-clinic to complete the consent forms.