CPRI
CHILD & PARENT RESOURCE INSTITUTE

Ontario

Referral for Tertiary Medical Consultation Service

This service offers a one-time consultation with a CPRI Paediatrician for a developmental-behavioural consultation, or Child & Adolescent Psychiatrist consultation. The child and family will be asked to attend the one time appointment. Referrals will only be accepted from a medical specialist (ie. Paediatrician, Psychiatrist, Neurologist, Geneticist, etc). All recommendations are provided back to the referring specialist. **If further CPRI services are required, a new referral full Intake package must be completed.**

REFER TO: (check one)
☐Developmental Paediatrics
☐Child & Adolescent Psychiatry

REQUIRED: Referent Question or Concern to be addressed (*please be specific*):

Your own recent consultation report and consent to the disclosure, transmittal or examination of a clinical record (see page 3, 4) is **required.** Also, please provide the most recent assessments completed on child, i.e., genetics, neurology, psychology, developmental, social work, etc.

☒Referent's recent consultation report ☒Consent completed (see pages 3,4)
☐Other (1): ☐Other (2):
☐Other (3): ☐Other (4):

Client Name: D.O.B.:

Sex: ☐Male ☐Female

Gender identity: ☐Male ☐Female ☐X

Client Current Address: City:

Postal Code: Telephone:

Health Card Number: Version Code: Expiry Date:

Custody currently with: ☐ Parents ☐ Father ☐ Mother ☐ Legal Guardian(s):
Other (please specify):

Parent/Guardian Name:

Parent/Guardian Current Address (if different from above):

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City:

Postal Code: Telephone:

Past involvement with CPRI: ☐ Yes ☐ No

Functional Level: ☐ Not Yet Determined ☐ Developmental Delay ☐ Average Range
☐ Gifted ☐Intellectual/Developmental Disability

Confirmed Diagnosis:
Provisional Diagnosis:

List Current Services/Supports:

Current/Past Medication Chart: (attach list if you need more space)

Current Medication	Dose	Date Started	Date Stopped	Side Effects Noted	Concerns
Past Medication	**Dose**	**Date Started**	**Date Stopped**	**Side Effects Noted**	**Concerns**

Date: Specialty Physician: Signature:

Billing #: Email: Fax:

PLEASE ENSURE YOU COMPLETE ALL PAGES OF THIS FORM.

Completed packages or questions can be emailed to: CPRI.Intake@ontario.ca

Fax (519) 858-2115

Ontario

Ministry of Children, Community and Social Services

Service Delivery Division
CPRI
600 Sanatorium Road
London ON N6H 3W7
Tel: (519) 858-2774
Fax: (519) 858-3913
TTY: (519) 858-0257

Ministère des Services à l'enfance et des services sociaux et communautaires

Division de la prestation des services
CPRI
600 Chemin Sanatorium
London ON N6H 3W7
Tel: (519) 858-2774
Téléc.: (519) 858-3913
ATME: (519) 858-0257

CB#

CONSENT TO THE DISCLOSURE, TRANSMITTAL OR EXAMINATION OF A CLINICAL RECORD

I, , , of

hereby authorize CPRI to examine/obtain from, transmit or disclose to:

(Include Full name/address of agency/school/physician)

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

the following: (check appropriate item(s))

☐ Educational Records

☐Clinical Records

in respect of for the purpose of: Assessment, Treatment and Planning Description of information to be examined/transmitted/disclosed:

☒Any pertinent information

☐Specifically:

Please note that this information may be released electronically, which includes by fax.

Unless otherwise stated, **this consent is valid for the length of time the child is receiving CPRI services and 1 year after all CPRI services are completed** (CPRI discharge) to allow:

- CPRI to assist you in your transition to other services as needed and/or,
- CPRI services to be re-activated within 1 year after your discharge when needed. I understand that I may revoke this consent in writing at any time.

This consent for examination, transmittal or disclosure of information has been fully explained to me. I understand it and agree with the examination, transmittal or disclosure.

Child/Youth Signature______________________________ Date ______________________

And/Or ☐ Consent of substitute decision-maker is required.

Guardian/Substitute Decision-Maker Signature Date ______________________

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GUIDELINES FOR COMPLETION OF CONSENT TO THE DISCLOSURE, TRANSMITTAL OR EXAMINATION OF A CLINICAL RECORD FORM

1. Please specify if you wish to DISCLOSE or OBTAIN information.
2. To DISCLOSE information:
   - list as many agencies, facilities, physicians, pediatricians, etc. that are involved with the child/youth's care
   - be sure to include the complete mailing address, if available
   - reports will not automatically be sent unless specified by a verbal or written request from CPRI clinicians
   - dictated reports that have carbon copies (c.c.) will be mailed out by Clinical Records staff
   - CPRI requires a consent with an ORIGINAL SIGNATURE in order to release information
3. To OBTAIN information:
   - use a separate consent form for each request as agencies, facilities, physicians, pediatricians, etc. require an ORIGINAL consent
   - for ease in processing, we are using a separate consent to obtain/disclose information from/to school boards/schools
   - when requesting a child's birth record, it is helpful to include the mother's surname (if different than the child's or if different at the time of the birth) and mother's date of birth

*****IF YOU HAVE ANY QUESTIONS CONCERNING THE ABOVE, PLEASE CONTACT EXTENSION 2024*****