DURHAM COMMUNITY HEALTH CENTRE

Our Health. Our Community. Our Durham.

1320 Airport Boulevard
Oshawa, ON L1J 0C6
Tel: (905) 743-9960
Fax: (905) 720-1292

Child, Youth, and Family Clinic Referral Form

Please fax completed referral form to 905-720-1292. Our medical secretary will follow up regarding an appointment.

Date of referral:

Check box if this is a DCAS Referral

Client details:

Name:

Address:

Date of Birth:

Client phone number:

Work:

Home:

Mobile:

Health card number (with version code):

Family physician (if applicable) name and phone number:

Referral from:

☐ Primary Care Provider ☐ other health service provider ☐ Self-referral ☑ Other

Details (include name of doctor or other health care provider and phone number):

Reason for referral:

- ☐ Primary Care
- ☐ Counselling Services
- ☐ Other
- ☐

Additional information:

CAS Worker Name(s), phone number and fax number (if applicable):

Legal Guardian name(s):

Address:

Phone Number:

Name of caregiver or parent who will be attending the appointment (if applicable):

Who lives in the home and relationship to client:

Medical History

Previous medical issues (please list any complications/medications/substance use during pregnancy, any complications with delivery, issues in the newborn period, hospitalizations, surgeries etc.)

Previous developmental concerns/delays?

Concerns at home (past and present):

Medications (past and present):

Allergies:

Are immunizations up to date? (Attach immunization record if available)

Family history of medical issues and mental health concerns:

Is the patient receiving any of the following services at present?

Counselling Services ☐
Psychiatry Services ☐
Workplace EAP ☐
Home and Community Care ☐