Breakwater Pediatrics

1175 Cook Street, Unit 328
Victoria, B.C., V8V 4A1
(P) 778-247-1175
(F) 250-984-0504
www.breakwaterpediatrics.ca

Please fax this form and relevant reports/investigations to: **250-984-0504**

This form is required for all referrals. **Should you perceive concern as medically urgent, the referring provider must speak directly with our office (778-247-1175) or the pediatrician on call at Victoria General**. Our office will confirm the referral has been received and/or accepted within a timely manner, and provide appointment details once arranged with the family.

REFERRAL DATE: _____

SECTION A: REFERRING PROVIDER ACKNOWLEDGES ALL OF THE FOLLOWING REQUIRED

- ☐ I understand this office pools referrals. If requesting a particular MD (accommodated only if possible), please specify in **Section D***
- ☐ The **legal guardian** is aware of referral. If not, referral will be declined.
- ☐ The patient is **not** currently under the care of another general pediatrician (or if a mental health concern, a child psychiatrist)
- ☐ I acknowledge referrals are only accepted for patients up to their 17th birthday

SECTION B: PATIENT DEMOGRAPHICS REQUIRED

Surname: Given Name: Middle Name(s): Gender:

PHN (or IFHP #): Date of Birth *(MM/DD/YYYY)*:

Phone 1: Phone 2: Email:

Address: City: Postal Code:

Referring provider name and MSP#: Primary care provider (if different from referring) and MSP#

Fax: Phone: Fax: Phone:

☐ Patient identifies as indigenous ☐ Patient is in care of MCFD ☐ Requires translator in _____

** Please send referral even if forms below not able to be completed*

SECTION C: REASON FOR REFERRAL REQUIRED

Reason for referral (**ONE** per referral)	Referring providers **MUST** complete all of the following, or the consultation request will be declined
☐ ADHD or behavior concern	☐ 1. I have verified the child is **not** currently being followed by a child psychiatrist ☐ 2. I have attached SNAP-IV scores from **both** school **and** home ☐ 3. I have attached feedback from the school: consider this CPS School questionnaire ☐ 4. I have directed family to Rolling with ADHD modules, to complete pending assessment ☐ 5. If behaviour challenge 3-12y, I have referred to Confident Parents Thriving Kids (no cost)
☐ Autism (Pre-school)	☐ 1. I have referred to the BC Autism Assessment Network at the Queen Alexandra Centre ☐ 2. I have referred the child to the Early Intervention Program at the Queen Alexandra Centre ☐ 3. I have referred the child for audiology assessment through Public Health ☐ 4. I have attached a *completed* M-CHAT (for children 16-30 months). Score of _____
☐ Autism (School-aged)	☐ 1. I have referred to the BC Autism Assessment Network at the Queen Alexandra Centre ☐ 2. I have referred the child for audiology assessment through Public Health (or privately) ☐ 3. I have attached a *completed* CAST assessment form. Score of _____

☐ Language delay (Pre-school)	☐ 1. I have referred the family to Public Health for speech language therapy (or to speechandhearingbc.ca if interested in private options) ☐ 2. I have referred the child for audiology assessment through Public Health ☐ 3. I have attached a *completed* M-CHAT (for children 16-30 months). Score of _____
☐ Anxiety (<13 yrs)	☐ 1. I have verified the child is **not** currently being followed by a child psychiatrist ☐ 2. I have attached *completed* SCARED Parent and Child forms ☐ 3. I have referred family to the Confident Parents Thriving Kids Anxiety Program (no cost) ☐ 4. I have recommended family self-refer to local Child & Youth Mental Health office (no cost)
☐ Anxiety (13+ yrs)	☐ 1. I have verified the child is **not** currently being followed by a child psychiatrist ☐ 2. I have attached a *completed* GAD-7. Score of _____ ☐ 3. I have referred to the CMHA Bounceback (Cognitive Based Therapy) Program (no cost)
☐ Depression	☐ 1. I have verified the child is **not** currently being followed by a child psychiatrist ☐ 2. I have attached a *completed* PHQ-9-A (For Adolescents) for 11-17 yrs. Score of _____ ☐ 3. I have advised the family to self-refer to local Child & Youth Mental Health office (no cost)
☐ Gender affirming care	☐ 1. I have attached the following: CBC, LH, FSH, estradiol or total testosterone (based upon sex assigned at birth), Vitamin D level, ECG. If <12 years, baseline DEXA scan requested ☐ 2. I have attached WHO Growth charts
☐ Obesity	☐ 1. I have attached WHO Growth chart and blood pressure
☐ Disordered eating	☐ 1. I have attached height, weight, orthostatic blood pressure and heart rate (full 2 minute interval) ☐ 2. I have attached CBC, extended electrolytes, glucose, Cr, BUN, ECG ☐ 3. I have referred the patient to the South Island Eating Disorders Program (SIEDP)
☐ Asthma/cough	☐ 1. I have requested a pulmonary function test (RJH) if 6 years or older
☐ Infant growth/feeding concern	☐ 1. I have attached WHO Growth chart including head circumference
☐ Other concern: _____	☐ 1. I have attached WHO Growth chart ☐ 2. I have attached documentation of physical exam

SECTION D: CONDITION DETAILS **REQUIRED**

Please detail your question/concern here (or attach separately). *Include medications, allergies, diagnoses, relevant exam findings*

Please direct your patient to breakwaterpediatrics.ca/resources for resources while awaiting consultation