Revised September 2025

Young Adult Mental Health
stellasplace.ca

**STELLA'S PLACE**
**REQUEST FOR PSYCHIATRIC CONSULTATION**

**HUB SITE:** **REFERRING CLINCIAN:**

| | |
|---|---|
| **Client Name** | |
| **D.O.B** ***(dd/mm/yyyy)*** | |
| **Address** | |
| **Contact Number** | |
| **Email** | |
| **Healthcard Number** | |

| **Presenting concern for Psychiatry (i.e., diagnostic clarification, medication review/suggestions)** |
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| |

| **Any known past psychiatric history? Please include if known – diagnosis, hospitalizations, history of suicide attempts, any known current medications?** |
|---|
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| **Any specific considerations for treating provider / psychiatrist? (i.e., gender / trauma/ potential conflicts of interest)** |
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*If there is a request for ADHD assessment / diagnostic clarification, please have the family forward any copies of past psychoeducational reports and/or IEPs*

**Please send completed form to our intake department by secure fax to 416-946-1404**