erica baker
PSYCHOLOGICAL SERVICES LIMITED

Psychoeducational Screening Assessment

Resident Referral Form (FELP)

Please note that we reserve the right to refuse service at our discretion if we believe the required services fall outside our areas of service or competency areas, or if we feel there is any concern of potential risk or safety concern to our psychologists, staff or clients.

☐ I understand

* Indicates required question

DATE*			
RESIDENT'S FIRST AND LAST NAME			
PHONE NUMBER		**EMAIL ADDRESS**	
RESIDENT'S DATE OF BIRTH			
RESIDENT'S AGE			
SELF-IDENTIFIED GENDER			

WHAT ETHNIC OR CULTURAL ORIGINS BEST DESCRIBES YOU? (INPUT IN SPACE BELOW OR CHECK BOXES)		
	☐ UNKNOWN	☐ PREFER NOT TO ANSWER

LANGUAGES SPOKEN		
☐ ENGLISH	☐ FRENCH	☐ OTHER (INPUT BELOW)
LANGUAGES WRITTEN		
☐ ENGLISH	☐ FRENCH	☐ OTHER (INPUT BELOW)

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Occupation/ School Information

CURRENT YEAR OF RESIDENCY	
AREA OF SPECIALTY	
WHERE WAS MEDICAL SCHOOL COMPLETED? (SCHOOL AND COUNTRY IF KNOWN)	
WHERE WAS UNDERGRADUATE TRAINING COMPLETED? (SCHOOL AND COUNTRY)	

Referral Information

REFERRAL SOURCE/ WHO IS SUGGESTING THIS ASSESSMENT?

IS AN INFORMAL OR FORMAL ENHANCED LEARNING PLAN (REMEDIATION) PLANNED OR IN PLACE?

ARE THERE ANY CONCERNS AROUND THE FOLLOWING:

** Check all that apply*

☐ 1. Learning (e.g. suspected or previously diagnosed Learning Disorder/ Learning Disability)
☐ 2. Cognitive (e.g. memory, executive functioning, language/ communication style)
☐ 3. Attention (e.g. suspected or previously diagnosed Attention-Deficit/ Hyperactivity Disorder)
☐ 4. Behaviour (e.g. emotional dysregulation, impulsivity)
☐ 5. Mental Health (e.g. depression, anxiety, OCD, etc…)
☐ 6. Suspected or previously diagnosed autism spectrum disorder
☐ 7. Trauma (e.g. complex trauma, PTSD)
☐ 8. Concussions or Traumatic Brain Injury
☐ 9. Other

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IF ANY CONCERNS ARE IDENTIFIED IN THE LIST ABOVE, PLEASE PROVIDE ADDITIONAL INFORMATION REGARDING EACH AREA OF CONCERN.		
HAVE THERE BEEN ANY <u>PREVIOUS</u> ASSESSMENTS COMPLETED? (I.E. PSYCHOEDUCATIONAL, NEUORPSYCHOLOGICAL, DIAGNOSTIC, SPEECH-LANGUAGE, ETC.)	☐ YES	☐ NO
IF 'YES' TO THE PREVIOUS QUESTION, HAVE ANY DIAGNOSES BEEN PROVIDED? PLEASE LIST		

PLEASE DESCRIBE YOUR REASONS AND GOALS FOR THIS REFERRAL:

REASONS (E.G. FAILED REMEDIATION, DIFFICULTIES WITH LEARNING, COMMUNICATION ISSUES, ETC.)

GOALS FOR ASSESSMENT SERVICES (E.G. LEARNING SUPPORT, POSSIBLE ACCOMMODATIONS, ETC.)

OTHER INFORMATION – PLEASE USE THIS SECTION TO PROVIDE ANY ADDITIONAL INFORMATION YOU MAY WISH TO SHARE WITH US

BY CHECKING THE BOX BELOW, I AM INDICATING THAT I UNDERSTAND THE ASSESSMENT MAY NOT LEAD A DIAGNOSIS AND/OR THE DIAGNOSIS MAY BE DIFFERENT THAN EXPECTED.

☐ I UNDERSTAND

A COLLATERAL SOURCE (PARENT, SIBLING, SPOUSE OR FRIEND) MAY BE REQUIRED FOR SOME OF OUR ASSESSMENTS. PLEASE NOTE THAT WE MAY NOT BE ABLE TO PROCEED IF THE RESIDENT CANNOT PROVIDE A COLLATERAL SOURCE.

☐ I UNDERSTAND

INFORMATION GATHERED AS PART OF THE INTAKE PROCESS WILL NOT BE SHARED WITH YOUR PROGRAM. A FINAL REPORT WILL BE PROVIDED TO YOU AND THE ASSISTANT DEAN OF RESIDENT AFFAIRS. THE ASSISTANT DEAN WILL REVIEW THE REPORT WITH YOU PRIOR TO ITS SUBMISSION TO YOUR PROGRAM/SITE DIRECTOR SO THAT ANY PERSONAL HEALTH INFORMATION CAN BE REDACTED.

☐ I UNDERSTAND

CONSENT TO RELEASE ACADEMIC RECORDS

I CONSENT TO THE RELEASE OF RELEVANT ACADEMIC RECORDS BY MY PROGRAM DIRECTOR AND/OR SITE DIRECTOR SOLELY FOR THE PURPOSE OF THIS ASSESSMENT. RECORDS THAT MAY BE SHARED INCLUDE REMEDIATION PLANS AND FORMATIVE AND SUMMATIVE ASSESSMENTS.

☐ I CONSENT	_____ SIGN HERE

COST AND INSURANCE INFORMATION

Your program will cover the cost of the assessment and any subsequent assessments that may be recommended

Please return complete forms to the Assistant Dean of Resident Affairs in your Jurisdiction (DMNS, DMNB, or CBMC). *

Click the following for: Resident Affairs - Contact Information