Physician Referrals to the Sexual Behaviours Clinic (SBC)

We accept referrals for people who:

- Are over the age of 18
- Are concerned about one or more of the following sexual interests:
    - Pedophilia
    - Bestiality
    - Exhibitionism
    - Voyeurism
    - Frotteurism
    - Coercive /violence

We will not accept a physician's referral for a patient who is currently on probation or parole for a sexual /sexually motivated offence. Their probation /parole officer **must** submit the referral.

Purpose of referral:

For patients seeking assessment for treatment recommendations for the above listed sexual interests.

Note: The initial intake assessment we provide to our patients is to determine and inform treatment needs. The report generated from our initial assessment will not comment on risk related to specific children.

Who can Make a referral?

- Physicians.
- The clinic **DOES NOT** accept referrals from CAS or lawyers. Please see website for more details.

Referrals must include:

- ☐ CAMH electronic form (with a detailed reason for referral).
- ☐ Bi-directional consent form (page two).
- ☐ Psychiatric or psychological reports and/ or assessments.

How to submit your referral?

Send to Access CAMH by completing the electronic form and attaching this referral package.

If you have any questions about making a referral, please call 416-535-8501 Ext: 32510.

camh

BI-DIRECTIONAL CONSENT FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

I _____
Client/Patient Name: (Print Last Name, First Name)

hereby authorize _____ to disclose and receive personal health information

to/from Sexual Behaviours Clinic - Centre for Addiction and Mental Health (CAMH)
Name of Person/Agency Requesting/Disclosing Information

of 1001 Queen Street W. Toronto Ontario M6J 1H4
Street Address City Province Postal Code

from the records of:

_____ _____ _____
Print Client/Patient Name Date of Birth (dd/mm/yyyy) Health Card #

_____
Street Address City Province Postal Code

I consent to the following specific information to be disclosed (please check all appropriate items):

- ☐ Mental health/addictions admission history
- ☐ Medical history (including lab results, ECGs, and urine drug screens)
- ☐ Progress notes during the time period below
  _____
- ☐ Medical and/or psychiatric consultation reports
- ☐ Discharge summary
- ☐ Medications summary
- ☐ Other (Please Specify):_____

How may this information be released (choose all that apply)? ☐ Verbally ☐ Photocopy

_____ _____
Signature of Witness Signature of Client/Patient

_____ _____
Print Name of Witness (if other than client/patient, print name and state relationship)

Date: _____
(dd/mm/yyyy)

Additional Instructions: _____

This authorization may be withdrawn in writing at any time.
All Consent for Disclosure of Personal Health Information forms must be delivered to the Health Records department to be processed. An administrative fee may be applied to cover photocopying and related costs.

FOR INTERNAL HEALTH RECORDS/CLINICAL STAFF USE ONLY
INFORMATION RELEASED BY: ☐ Verbal Communication ☐ Mail ☐ Fax

F0140-20060825

Virtual Appointment Scheduling

A virtual appointment requires the patient to have access to:

- A smart phone / tablet / computer with a camera and microphone
- Access to a strong internet connection
- A private space for approximately 2-3 hours

Can this patient attend a virtual appointment?

- ☐ Yes
- ☐ No

If yes, provide an email for this patient. Our staff will connect directly with this patient to schedule the initial assessment.

Email for client: _____

This email will be used to send:

- Appointment details
- Virtual appointment link
- Registration forms and assessment consent form

Patients who are unable to attend a virtual appointment

Our staff will connect with them / you directly when we are ready to schedule the initial assessment as an in person appointment.