Mackenzie Health

Mackenzie Richmond Hill Hospital
10 Trench Street
Richmond Hill, Ontario
L4C 4Z3

Y: _____

Name: _____

Place Patient Barcode Label Here

Mental Health Adult Outpatient Referral Form

Centralized Intake: 905-883-2127 or 905-832-4554 ext. 2127

Fax: 905-883-2139

The Outpatient Mental Health Program accepts referrals where there is a primary psychiatric concern. We provide short term consultation and stabilization. Upon receipt of your completed referral, our central intake team will review and determine how to best serve your patient. If our central intake team determines that your patient requires urgent intervention, our goal is to see them within 14 days.

We are NOT able to accept referrals for assessments / treatment where concerns are related principally to:

Adult ADHD	Chronic pain	Primary Substance Abuse
Anger management	Developmental delay	Relationship counselling
Autism Spectrum Disorders	Eating disorder	Sexual trauma

We do not provide assessments for Legal, Insurance, Custody, CAS, WSIB or Forensic reasons

Is the patient involved in current/pending legal, compensation or insurance claims? ☐ Yes ☐ No

If yes, please explain: _____

CLIENT INFORMATION: Date patient was last seen? _____ yyyy/mm/dd

Is patient agreeable to referral? ☐ Yes

Patient name: Last, first name		**Date of Birth:** yyyy/mm/dd
Address:		
Sex: ☐ Male ☐ Female	**Health Card Number:**	**Version Code:**
Home #:	* Can leave a message at this number? ☐ Yes ☐ No	
Cell #:	* Can leave a message at this number? ☐ Yes ☐ No	

Email Address of primary contact for referral (required) _____

(Please ensure your patient is aware of regularly check their "Junk" box as often email servers are filtering the hospital emails to "Junk" due to their settings)

**** Due to Privacy Legislation the hospital requires this field to be completed before the patient can be contacted.***

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

(This information is required by the hospital to register the patient)

REFERRAL INFORMATION: Referrals must be made by a physician

Referred by: ☐ Family physician ☐ Psychiatrist ☐ Other _____

Referring Physician's Name: _____ **Billing No:** _____

Telephone #: _____ Fax #: _____

Is there a need for an interpreter? (e.g., for sign language or other language) ☐ No ☐ Yes _____

SERVICE REQUEST (Choose ONE)

☐ **Psychiatric Consult**	☐ **Counselling SW/RN Therapist-short term**	☐ **Psychogeriatric Program**
☐ Diagnostic Clarification	☐ **Stepping Stones - Day Program**	☐ **Neuropsychiatry**
☐ Medication Review	☐ **OTN**	

Reason for Referral: Please provide previous consultation notes, (required field).

Print Form

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Centralized Intake

Current Medications	Past Medications / Side effects if any / Reason for discontinuation

Medical Condition

Must be completed

☐ No Known Allergies Allergies: _____

Factors contributing to current referral:

- ☐ appetite changes
- ☐ cognitive changes
- ☐ compulsive behaviours
- ☐ decreased energy
- ☐ decrease in self care
- ☐ depressed mood / sad for more than two weeks
- ☐ sleep changes
- ☐ social withdrawal
- ☐ panic attacks
- ☐ significant anxiety / fears
- ☐ Alcohol / Drug use
- ☐ racing thoughts
- ☐ psychomotor retardations or agitation
- ☐ delusions
- ☐ hallucinations
- ☐ disorganized thoughts or speech

RISKS:			Please explain:
Threat to self	☐ No	☐ Yes	When:
Threat to others	☐ No	☐ Yes	When:
Suicidal Ideation / Plan / Intent	☐ No	☐ Yes	When / Describe:
Violent behaviour	☐ No	☐ Yes	When:

If you have a concern that a patient is actively suicidal/homicidal please direct them to the **Emergency Department**

Please provide the details for urgency:

Incomplete referrals will be returned

☐ **Patient has been told that they must call the Activation line at 905-883-1212 or 905-832-4554 ext. 4853 to initiate the processing of the referral, otherwise the referral will be closed.**

(Due to high volume of no show appointments, your patient is required to Activate this referral to ensure that they do want to continue with the referral and attended the appointment)

Physician Name: _____ Signature: _____ Date: _____ (yyyy/mm/dd)

WE WILL CONTACT YOUR PATIENT DIRECTLY