

**Mental Health Adult Outpatient Referral Form**

Place Patient Barcode Label Here

Central Intake: 905-883-2127

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	Domestic Sexual Trauma

**We do not provide assessment 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: \_\_\_\_\_

<b>CLIENT INFORMATION: Date patient was last seen?</b> _____ (dd/mm/yyyy)	
Is patient agreeable to referral? <input type="checkbox"/> Yes	
<b>Patient Name:</b> (Last, First Name) _____	<b>Date of Birth:</b> _____ (dd/mm/yyyy)
<b>Address:</b> _____	
<b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Health Card Number:</b> _____
<b>Version Code:</b> _____	
<b>Home #:</b> _____	*Can we leave a message at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Cell #:</b> _____	*Can we leave a message at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Email Address of primary contact for referral (required)</b> _____ <i>(Please ensure your patient is aware of regularly check their "Junk" as often email servers are filtering the hospital emails to "Junk" due to their settings)</i>	
<b>*Due to Privacy Legislation to hospital requires this field to be completed before the patient can be contacted.</b>	
<b>Marital status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <i>(This information is required by the hospital to register the patient)</i>	
<b>REFERRAL INFORMATION:</b> Referrals must be made by a physician	
<b>Referred by:</b> <input type="checkbox"/> Family physician <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other _____	
<b>Referring Physician's Name:</b> _____	<b>Billing No:</b> _____
<b>Telephone Number:</b> _____	<b>Fax Number:</b> _____
Is there a need for an interpreter (e.g., for sign language or other language) <input type="checkbox"/> No <input type="checkbox"/> Yes _____	
<b>SERVICE REQUEST (Choose ONE)</b>	
<input type="checkbox"/> <b>Psychiatric Consult</b>	<input type="checkbox"/> <b>Counselling SW/RN Therapist-short term</b>
<input type="checkbox"/> <b>Diagnostic Clarification</b>	<input type="checkbox"/> <b>Stepping Stones – Day Program</b>
<input type="checkbox"/> <b>Medication Review</b>	<input type="checkbox"/> <b>Psychogeriatric Program</b>
	<input type="checkbox"/> <b>Neuropsychiatry</b>
<b>Reason for Referral:</b> Please provide previous consultation notes, (required field). _____ _____ _____	



Patient Name: \_\_\_\_\_

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**Central 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**

<input type="checkbox"/> appetite changes	<input type="checkbox"/> depressed mood / sad for more than two weeks	<input type="checkbox"/> alcohol / drug use
<input type="checkbox"/> cognitive changes	<input type="checkbox"/> sleep changes	<input type="checkbox"/> racing thoughts
<input type="checkbox"/> compulsive behaviours	<input type="checkbox"/> social withdrawal	<input type="checkbox"/> psychomotor retardations or agitation
<input type="checkbox"/> decreased energy	<input type="checkbox"/> panic attacks	<input type="checkbox"/> delusions
<input type="checkbox"/> decrease in self care	<input type="checkbox"/> significant anxiety / fears	<input type="checkbox"/> hallucinations
		<input type="checkbox"/> disorganized thoughts or speech

RISKS	Please explain:		
Threat to self	<input type="checkbox"/> No	<input type="checkbox"/> Yes	When:
Threat to others	<input type="checkbox"/> No	<input type="checkbox"/> Yes	When:
Suicidal Ideation /Plan /Intent	<input type="checkbox"/> No	<input type="checkbox"/> Yes	When/Describe:
Violent behavior	<input type="checkbox"/> No	<input type="checkbox"/> 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 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: \_\_\_\_\_ (dd/mm/yyyy)

**WE WILL CONTACT YOUR PATIENT DIRECTLY**