

Adult Outpatient Referral Form – Mental Health and Addictions

Please **DO NOT** Fax this cover sheet with the referral

For Referring Providers

- ∞ Niagara Health Outpatient Mental Health and Addictions Program offers evidence-based assessments / treatment for adults.
- ∞ A physician / nurse practitioner referral is required for most services.
- ∞ Niagara Health **does not** offer:
 - Individual counselling
 - Grief / bereavement services
 - Anger management services
 - Assessments for complex dual diagnosis
 - Assessment, treatment and/or rehabilitation for acquired brain injury (ABI), traumatic brain injury (TBI) or concussion
 - Parenting capacity / custody access or forensic assessments
 - Assessments for the Ontario Disability Support Program (ODSP) or insurance providers / workplace
 - Assessment for legal purposes (criminal or civil)

For Your Client

- ∞ Please ensure your client is aware that the referral is being made.
- ∞ A mental health clinician will review each referral.
- ∞ Two attempts will be made to call the client. A letter will be sent to the referring provider if no contact is made.
- ∞ Some services may have a waitlist and clients will be informed of this when contact is made.
- ∞ Please provide the **While You Wait Resources** to assist the client in getting the most out of the wait time by checking out the online and self-directed resources.

How to Refer to Outpatient Mental Health and Addiction Services

- ∞ Fax the completed referral form to **905-704-4420**.
- ∞ Pages 1 and 2 must be completed in full for all referrals.
- ∞ Additional Required Information form must be completed for all Medication Clinic (Page 3), ECT (Page 4) and rTMS (Page 5) referrals.
- ∞ **AVOID DELAYS** – incomplete referrals delay care for your client. Ensure that all sections of the referral form are complete and all necessary information is included. All incomplete referral forms will be returned to the referring provider.
- ∞ For any enquiries, please call **905-378-4647 Extension 49613**.

Psychiatric Consultation (CAPS):

- ∞ **Inclusion Criteria:**
 - **One-time psychiatric consultation** is available with the understanding that the referring physician is responsible for the implementation of recommendations.
 - CAPS does not provide "second opinion" consults.
 - For conditions related to depressive and anxiety disorders, there must be evidence of two medication trials within the current episode of illness.
 - For conditions related to depression a PHQ-9 (completed by client) must be included with the referral.
 - For conditions related to anxiety a GAD7 (completed by client) must be included with the referral.
 - For first episode psychotic disorders, please refer to Niagara Region First Episode Psychosis Program, if appropriate

Rapid Access Addiction Medicine (RAAM)

- ∞ **Inclusion Criteria:**
 - Assessments and treatments for substance use problems such as alcohol, opioids, cocaine, benzodiazepines, and cannabis
 - Medications may be prescribed for substance use, withdrawal, and craving, opioid agonist treatment with methadone and buprenorphine
 - Any questions, please call **905-378-4647 Extension 49463**.



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SECTION A: Client Information

Is client aware of referral? Yes No

Client Name: _____ HC with Version Code: _____
 Preferred Name: _____ **OR** Other Coverage (copy attached)
 Address: _____ City/Town: _____
 Primary Contact: _____ Can a message be left at this number? Yes No
 Can we use e-mail for appointment communication? Y E-mail Address: _____ No
 Services may be provided virtually – E-mail Address: _____ Same as above?
 Date of Birth: _____ (dd/mm/yyyy) Identify as First Nations/Indigenous? Y N
 Birth Gender: Male Female Prefer not to Answer Prefer to Self-Identify _____
 Preferred language? English Other: _____ Require Interpreter? Y language _____ N
 Emergency Contact: Relationship _____ Contact: _____
 Indicate all that apply: Cognitive Impairment Hearing Impairment Visual Impairment
 Mobility / Fall Risk Bariatric Sensory Therapy Animal Support Worker Other: _____
 Primary Care Provider: _____ Phone Number: _____

SECTION B. (If referring to multiple programs, please number priority of services)

Program Requested:	Reason for Referral:	
# _____ CAPS – Centralized Access to Psychiatric Services (Physician/NP referral only)	<input type="checkbox"/> Assessment <input type="checkbox"/> Diagnostic Clarifications <input type="checkbox"/> PHQ-9 attached	<input type="checkbox"/> Medication Recommendations <input type="checkbox"/> Medication trials included <input type="checkbox"/> GAD7 attached
# _____ Urgent Access NP (NH ED Physician Only)	<input type="checkbox"/> Assessment <input type="checkbox"/> Diagnostic Clarifications	<input type="checkbox"/> Medication Recommendations
# _____ RAAM – Rapid Access to Addiction Medicine	<input type="checkbox"/> Alcohol <input type="checkbox"/> Opiates	<input type="checkbox"/> Other:
# _____ Seniors Mental Health (Physician/NP referral only)	<input type="checkbox"/> Assessment	<input type="checkbox"/> Diagnostic Clarification <input type="checkbox"/> Medication Recommendations
# _____ Adult Group Therapy (check one diagnosis)	<input type="checkbox"/> Anxiety <input type="checkbox"/> Bipolar <input type="checkbox"/> Depression	<input type="checkbox"/> Emotion Dysregulation <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Concurrent/Other:
# _____ Day Hospital	<input type="checkbox"/> Complex mental health ONLY mood, anxiety or thought disorders <input type="checkbox"/> Impairments with daily functioning	
# _____ STAR – Skills Training And Recovery	Must meet ALL the following criteria <input type="checkbox"/> History of trauma <input type="checkbox"/> Current trauma symptoms Impedes daily functioning <input type="checkbox"/> Severe emotion dysregulation <input type="checkbox"/> Participate mixed gender groups	
# _____ Medication Clinic	to complete this referral you must go to page 3 to input additional required information	
# _____ ECT Electroconvulsive Therapy	to complete this referral, you must go to Page 4 for additional input	
# _____ rTMS Repetitive Transcranial Magnetic Stimulation	to complete this referral, you must go to Page 5	
# _____ CTO Community Treatment Order (Community referrals only)	Assess suitability: <input type="checkbox"/> 30+ days inpatient mental health admission within past 3 years <input type="checkbox"/> 2 lengthy inpatient mental health admissions within past 3 years <input type="checkbox"/> previous CTO in the past _____	

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Chart Copy – Do Not Destroy

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SECTION C: PRESENTING SYMPTOMS:

Current challenges / concerns: _____

Previous / Current Mental Health Diagnosis (**must indicate mild / moderate / severe** as per PHQ-9): attached PHQ-9

Previous / Current Medical Diagnosis: _____

Medication/Supplements (both psychiatric and non-psychiatric medication) Medication List attached / additional attached

Medication	Current	Dose	Frequency	Response and Adverse Effects
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Medication Trials: <input type="checkbox"/> No <input type="checkbox"/> Yes (fill out below) OR <input type="checkbox"/> Client declined trials				
Medication Trials	Current	Dose	Frequency	Response and Adverse Effect
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			

Allergies: _____

SECTION D: RISK Please complete the following chart:

Problem	Within past 3 months		More than 3 months		Not Applicable	Details
	Yes	No	Yes	No		
Alcohol / Substance Use						
Physically Violent						
Suicidal Ideation						
Suicidal Attempts						
Self-Harming						
Homicidal Threat/Ideation						
Homeless / Risk Of						

Concerns regarding any immediate risk issues, please contact COAST or call 911. We do not provide crisis response services.

If answered yes above, please identify / report concerns: _____

Primary Care Referring (print & sign): _____ Billing #: _____

Referring Number: _____ Referral Fax: _____ Referral Date: _____



REF41



Rapid Access Addictions Medicine (RAAM) Clinic
PATIENT INFORMATION SHEET

Affix Patient Label

What Will
Happen Next?

You have been referred to The RAAM (Rapid Access Addictions Medicine) Clinic. It is for people looking for help with their substance use (alcohol and/or other drugs). The clinic will contact you in the next couple of days for your appointment. If you do not hear from them within 2 business days, please contact them at 905 378 4647 x49463.

The doctors at RAAM clinic have experience treating people who are struggling with substance use and know how difficult it is to ask for help. You can always self refer to the clinic.

How To Get to the
Clinic?

The Clinic is situated at the main floor of the St. Catharines Site on 1200 Fourth Avenue. Go to the Mental Health Program Entrance Patient Registration window to register on the day of your appointment. This is located at the South-East corner of the building and has parking close by.

If you are feeling nervous or hesitant about going to the clinic, feel free to bring along a supportive friend or family member. You are welcome to come to the clinic even if you are not sure that you have a substance use problem or if you know you have a problem but you are not ready to stop yet.

Why Addictions
Medicine?

A substance use disorder is a medical diagnosis for problematic drug/alcohol use (using more than intended, spending a lot of time getting and using substances) that results in negative life consequences (problems at home, work or health, spending less time on things you enjoy, etc.). Depending on how you use these substances and the consequences, the doctor may diagnose you with this disorder. Substance use disorders are treatable conditions and with help, people can and do recover.

There are multiple effective medications that may be offered for treatment of substance use, withdrawal, and craving. These medications may relieve these symptoms and then allow you to focus on establishing a healthy lifestyle. The RAAM clinic doctor may refer you to counseling as part of your treatment. Treatment and/or referrals may also be offered as necessary for any co-occurring mental illness that you may have.

Family
Doctors

Your family doctor is central in your overall healthcare. If you do not have a family doctor, we strongly advise you to get one. You can find help at www.niagaradocs.ca or by calling **Healthcare Connect Ontario at 1-800-445- 1822**. The city of St Catharines provides similar information on their website www.stcatharines.ca or by calling 905.359.6043.

Thank you

PLEASE GIVE TO THE PATIENT BEFORE DISCHARGE FROM ED



Niagara Health System
Système De Santé De Niagara

St. Catharines Site

1200 Fourth Avenue, St. Catharines, ON, L2S 0A9

Telephone 905-378-4647

www.niagarahealth.on.ca

Name _____

Address _____

R_x

Date _____

Suboxone (Buprenorphine/Naloxon)

Sub Lingual Tab

Daily Witnessed Administration

Dose (as checked):

2mg/0.5mg

4mg/1mg

8mg/2mg

For 7 days only Start Date _____

LU Code 438 End Date _____

PS2500

DR. _____

DO NOT REPEAT

PHARMACIST _____