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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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Pages 1 and 2 must be completed in full for *all* referrals (incomplete forms *will not* be processed)
Additional Required Information Form must be completed for all referrals Medication Clinic (Pg. 3), ECT (Pg. 4), rTMS (Pg. 5)
Please fax all referrals to 905−704−4420. For any enquiries, please call Intake at 905−378−4647 Ext. 49613

SECTION A: Client Information

Is client aware of referral? ☐ **Yes** ☐ **No** **Is client at risk to self/others?** ☐ **Yes** ☐ **No**

Client Name: _____ HC with Version Code: _____

Address: _____ City/Town: _____

Telephone: (H) _____ leave message ☐ Y ☐ N (C) _____ leave message ☐ Y ☐ N

Must Include E−mail: _____

All our services are provided virtually. If unable to participate virtually and/or without an e−mail, please provide details: _____

_____

Date of Birth: _____ (dd/mm/yyyy) Birth Gender: ☐ Male ☐ Female Identified Gender: _____

English primary language? ☐ Y ☐ N Language of preference? _____

Require Interpreter? ☐ Y − language_____ ☐ N Identify as First Nations/Indigenous? ☐ Y ☐ N

Name of Family Physician: _____ 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	☐ Assessment ☐ Diagnostic Clarifications ☐ PHQ−9 attached	☐ Medication Recommendations ☐ Medication trials included ☐ GAD7 attached
#____ Urgent Access NP **(NH ED Physician Only)**	☐ Assessment ☐ Diagnostic Clarifications	☐ Medication Recommendations
#____ RAAM − Rapid Access to Addiction Medicine	☐ Alcohol ☐ Opiates	☐ Other:
#____ Seniors Mental Health **(Physician/NP referral only)**	☐ Cognitive Decline ☐ New Mental Health	☐ Diagnostic Clarifications ☐ Medication Recommendations
Contact Person for Appointment: _____ Relationship: _____ Phone Number: _____ INCLUDE ALL RECENT LAB WORK, CT/MRI HEAD, BMD, RELEVANT CONSULTATIONS		
#____ Adult Group Therapy (check one diagnosis)	☐ Anxiety ☐ Bipolar ☐ Depression	☐ Emotion Dysregulation ☐ Schizophrenia ☐ Concurrent/Other:
#____ Day Hospital (3 days per week SCS only)	☐ Complex mental health ONLY mood, anxiety or thought disorders ☐ Impairments with daily functioning	
#____ STAR − Skills Training And Recovery (formerly GEM)	**Must meet ALL the following criteria** ☐ History of trauma ☐ Severe emotion dysregulation ☐ Participate mixed gender groups	☐ Current trauma symptoms Impedes daily functioning

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SECTION B: (Continued)
Program Requested: | **Reason for Referral:**

#____ 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 also go to Page 4** for additional input

#____ rTMS − Repetitive Transcranial Magnetic Stimulation − to complete this referral, **you must also go to Page 5**

#____ CTO – Community Treatment Order
(Community / outpatient referrals only)

Assess Suitability
- ☐ 30+ days inpatient mental health admission within past 3 years
- ☐ 2 lengthy inpatient mental health admissions within past 3 years
- ☐ Previous CTO in the past

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 (both psychiatric and non−psychiatric medication) ☐ Medication List attached / additional attached

Medication	Current	Dose	Frequency	Response and Adverse Effects
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			

Allergies: _____

SECTION D: RISK **Please complete the following chart:**

Problem	Present (within past 6 months)		Past (6 months or more)		Denied	Unknown
	Yes	No	Yes	No		
Alcohol / Substance Use	☐	☐	☐	☐	☐	☐
Violent Behaviour	☐	☐	☐	☐	☐	☐
Suicidal Ideation	☐	☐	☐	☐	☐	☐
Suicidal Attempts	☐	☐	☐	☐	☐	☐
Self−Harming Behaviour	☐	☐	☐	☐	☐	☐

If you have 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: _____

Completed by (print & sign): _____ MD/NP Billing #: _____

Referring Unit (Internal Only): _____ Referring Source Fax: _____

Referring Source Phone: _____ Referral Date: _____ (dd/mm/yyyy)

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Additional Required Information − Medication Clinic:
For any enquiries, please call Intake at 905−378−4647 Ext. 49613

☐ NEW Niagara Health Medication Client **OR** ☐ ACTIVE Niagara Health Medication Client

Name of NH Psychiatrist referring:	
MUST HAVE Name of Psychiatrist providing follow up:	☐ referent will support Medication Clinic **OR** _____
Name and Dosage of Prescribed Long Acting Medication: ☐ LAI: ☐ Clozaril® (clozapine) New Client: ☐ CSAN #: _____ ☐ attached CSAN Enrollment Form ☐ Generic Brand / Clozaril® ☐ Monitoring Portal: _____	☐ Attached discharge prescription with # of refills for Medication Clinic Use (small orange)
Next dosage due date / dosage amount:	
Frequency of medication given	
Medication Start Date (dd/mm/yyyy):	
Date Medication / Injection Last Given (dd/mm/yyyy):	
Attached separate prescription for LAI / Clozaril® and these medications say "**Do Not Fill"** on discharge BPMH	☐ Yes
Clozaril® in client's hand at discharge from inpatient unit?	☐ Yes ☐ No ☐ Not Applicable
How often is blood work to be completed for Clozaril®?	☐ Not Applicable
Follow Up Appointment for Outpatient Medication Clinic?	☐ Yes _____ ☐ No
Follow Up Appointment Made for Psychiatrist / NP?	☐ Yes _____ ☐ No
Client Aware of Medication Clinic Location?	☐ Yes ☐ No
How is client paying for Medication? (ODSP, CPP, Trillium)	☐ Attached copy of private insurance medication plan _____
Pharmacy where drug card being used:	
Client has transportation to Medication Clinic?	☐ Yes _____ ☐ No
Who is bringing client to appointment at clinic?	☐ Client ☐ Name/Contact #:
Additional Contact Person Name and Number?	☐ Yes _____ ☐ No

Referring Unit (Internal Only):	CN (print/sign − Internal Only):

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Additional Required Information − ECT − Electroconvulsive Therapy:
Clients **MUST** have had a psychiatric / mental health assessment by GP, psychiatrist or NP within past 6 months.
If not, please refer to CAPS for assessment and diagnostic clarification

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Treatment − resistant depression	☐ Yes ☐ No
Major depressive disorder with psychotic feature	☐ Yes ☐ No
Unable to tolerate antidepressant medications	☐ Yes ☐ No
Mania non−responsive to pharmacological treatment	☐ Yes ☐ No
Acutely suicidal	☐ Yes ☐ No
Malnourished / dehydrated, rapidly deteriorating physical status	☐ Yes ☐ No
Schizophrenia − antipsychotic non−responsive	☐ Yes ☐ No
Prior ECT favourable response	☐ Yes ☐ No
Other indication for ECT	☐ Yes ☐ No

Previous ECT details (name of institution, describe the type of ECT, if bilateral / unilateral, number of treatments, response and any unusual side effects).

General Anaesthesia History: any complications with general anaesthetic? ☐ Yes ☐ No

Consent: Is the person competent to consent to treatment? ☐ Yes ☐ No
If "No" who is the substitute decision maker / contact number? _____

Lab / Diagnostic Tests must be sent with this referral: CBC, TSH, B12, Sodium, Potassium, Chloride, Ca, Mg, Phosphate, AST, ALT, GGT, ALP, Bilirubin, BUN, Creatinine, Fe, Urinalysis, EKG and any other relevant tests / procedures / consultation notes

Internal Use Only:

Anaesthesia Consult: _____ **Physician Consult:** _____ **First ECT:** _____

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Additional Required Information − rTMS − Repetitive Transcranial Magnetic Stimulation:
Clients **MUST** have had a psychiatric / mental health assessment by psychiatrist or NP within past 6 months.
If not, please refer to CAPS for assessment and diagnostic clarification

Please fax all referrals to 905−704−4420. For any enquiries, please call Intake at 905−378−4647 Ext. 49613

Indications for rTMS:

Major depressive disorder	☐ Yes ☐ No	**Please elaborate for each "Yes" indication**

Potential Contraindications for rTMS:

History of epileptic seizures	☐ Yes ☐ No	
History of stroke	☐ Yes ☐ No	
Family history of epilepsy	☐ Yes ☐ No	
History of syncopal episodes	☐ Yes ☐ No	
Head trauma with loss of consciousness	☐ Yes ☐ No	
Cardiac disease	☐ Yes ☐ No	
Cardiac arrhythmia	☐ Yes ☐ No	
Implanted cardiac pacemaker or defibrillator	☐ Yes ☐ No	
Implanted DBS or other neurostimulator	☐ Yes ☐ No	
Cochlear implant	☐ Yes ☐ No	
Medication infusion device	☐ Yes ☐ No	
Aneurysm clip or coils	☐ Yes ☐ No	
Metallic implant or other foreign body	☐ Yes ☐ No	
Ever have metal fragments in eye	☐ Yes ☐ No	
History of metal work	☐ Yes ☐ No	
History of spinal surgery	☐ Yes ☐ No	
Impairment of vulnerability of hearing	☐ Yes ☐ No	
History / current alcohol use	☐ Yes ☐ No	
Pregnancy	☐ Yes ☐ No	
Chronic neck / back pain	☐ Yes ☐ No	

Internal Use Only: ☐ **Previous rTMS** ☐ **Previous ECT**

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