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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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INSTRUCTION PAGE – Not for Chart

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Mental Health and Addictions

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 (NO ED Physician only)	☐ Assessment ☐ Diagnostic Clarification	☐ 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						

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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)

REF41

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NIAGARA HEALTH SYSTEM
SYSTÈME DE SANTÉ DE NIAGARA

Rapid Access Addictions Medicine (RAAM) Clinic
PATEINT 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____

℞

Date ________________________

Suboxone (Buprenorphine/Naloxon)

Sub Lingual Tab

Daily Witnessed Administration

Dose (as checked):

[ ] 2mg/0.5mg

[ ] 4mg/1mg

[ ] 8mg/2mg

[ ] ______________

For 7 days only

LU Code 438

Start Date ________________

End Date ________________

PS2500

DR.______________________________

DO NOT REPEAT

PHARMACIST______________________