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Extraordinary Caring. Every Person. Every Time.

Adult Outpatient Referral Form
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**

Client Name: ______________________ HC with Version Code: ______________________
Address: ______________________ City/Town: ______________________
Telephone: (H) ______________ leave message ☐ Y ☐ N (C) ______________ leave message ☐ Y ☐ N
Date of Birth: ______________ (dd/mm/yyyy) Birth Gender: ☐ Male ☐ Female Identified Gender: ________
Name of Family Physician: ______________________ Phone Number: ______________________
Psychiatrist: ______________________ Phone Number: ______________________

SECTION B: (if referring to multiple programs, please number priority of services)

Program Requested:	**Reason for Referral:**	**Internal Use Only:**
☐ CAPS – Centralized Access to Psychiatric Services #____ **(physician/NP referral only)**	☐ Assessment ☐ Diagnostic Clarifications ☐ Medication Recommendations	Appt. Date: ________ Completed: ________ See Notes: ☐ Yes ☐ N/A
☐ Urgent Access Nurse Practitioner **(NH ED Physician Only)** #____	☐ Assessment ☐ Diagnostic Clarifications ☐ Medication Recommendations	Appt. Date: ________ Completed: ________ See Notes: ☐ Yes ☐ N/A
☐ RAAM – Rapid Access to Addiction Medicine #____	☐ Alcohol ☐ Opiates ☐ Other:	Appt. Date: ________ Completed: ________ See Notes: ☐ Yes ☐ N/A
☐ Seniors Mental Health #____ **(physician/NP referral only)** Contact Person for Appointment: ______________________ Relationship: ____________ Phone Number: ____________ INCLUDE ALL RECENT LAB WORK, CT/MRI HEAD, BMD, RELEVANT CONSULTATIONS	☐ Cognitive Decline ☐ New Mental Health ☐ Longstanding Mental Health	Appt. Date: ________ Completed: ________ See Notes: ☐ Yes ☐ N/A
☐ WRICCP – Wellness Recovery Integrated Comprehensive Care Program #____	**Must meet ALL the following criteria:** ☐ Recent suicide attempt ☐ Recent / frequent ED / Admission Inpatient ☐ Acute phase of mental health illness ☐ Significant impact to functioning	Appt. Date: ________ Completed: ________ See Notes: ☐ Yes ☐ N/A
☐ Adult Group Therapy (check one) ☐ Depression ☐ Anxiety #____ ☐ Schizophrenia ☐ ADHD	☐ Bipolar ☐ Emotion Dysregulation ☐ Pain Control and Wellness	Appt. Date: ________ Completed: ________ See Notes: ☐ Yes ☐ N/A
☐ Day Hospital (3 days per week SCS only) #____	☐ Complex mental health ☐ Impairments with daily functioning	Appt. Date: ________ Completed: ________ See Notes: ☐ Yes ☐ N/A
☐ GEM – Guiding Emotions Mindfully (1.5 days per week SCS only) #____	☐ Severe emotion dysregulation ☐ History of trauma	Appt. Date: ________ Completed: ________ See Notes: ☐ Yes ☐ N/A
☐ Medication Clinic – to complete this referral **you must also go to page 3** to input additional required information #____		Appt. Date: ________ Completed: ________ See Notes: ☐ Yes ☐ N/A

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SECTION B: (Continued)

Program Requested:	Reason for Referral:	Internal Use Only:
☐ ECT – Electroconvulsive Therapy – to complete this referral, you must also go to Page 4 to input additional required information #____		Appt. Date: ______________ Completed: ______________ See Notes: ☐ Yes ☐ N/A
☐ rTMS – Repetitive Transcranial Magnetic Stimulation – to complete this referral, you must also go to Page 5 to input additional required information #____		Appt. Date: ______________ Completed: ______________ See Notes: ☐ Yes ☐ N/A
☐ CTO – Community Treatment Order #____	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	Appt. Date: ______________ Completed: ______________ See Notes: ☐ Yes ☐ N/A

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: ____

____

Previous / Current Medication(s) / Dosages: ☐ attached medication list

____

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 answered yes above, please identify / report concerns: ____

____

Referring Source (print): ____________________ MD/NP Billing #: ____________________

Referring Source Phone: ____________________ Referring Source Fax: ____________________

Signature: ____________________ Referral Date: ____________________ (dd/mm/yyyy)

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