PRHC Mental Health & Addictions Services Referral

PATIENT LABEL

Date of Referral (DD/MM/YYYY): _____

K#: _____ Status: _____

Please note this is not a crisis service. If you need immediate support, please call or text 9-8-8 toll-free, anytime, or visit the closest Emergency Department. ***We do not conduct assessments for legal or child custody purposes or insurance claims.***

CLIENT/PATIENT INFORMATION

Name:	DOB (DD/MM/YYYY):	☐ Male ☐ Female ☐ Other
OHIP #:	Address:	

Method of contact (Choose all that you consent to): ☐ Phone #: _____ ☐ Cell #: _____ ☐ Mail

☐ Email: _____ Can we leave messages? ☐ Yes ☐ No

Next of Kin: _____ Relationship to client: _____ Phone #: _____

Language: _____ Is an interpreter required? ☐ Yes ☐ No Is client aware of this referral? ☐ Yes ☐ No

Are any of the following responsible for medical decisions? ☐ Power of Attorney ☐ Substitute Decision Maker ☐ Trustee

Name of contact: _____

PRESENTING PROBLEMS
(symptoms, duration, severity and contributing factors)

GAD 7 score: _____ PHQ9 Score: _____

Diagnostic Impressions:

REFERRING SOURCE NAME: _____

Telephone: _____ Fax: _____

Billing #: _____

Referral Signature: _____

PRIMARY PHYSICIAN NAME: _____

Telephone: _____ Fax: _____

Billing #: _____

REASON FOR REFERRAL: (symptoms, duration and goal, etc.)

Impact on daily functioning: ☐ Mild ☐ Moderate ☐ Severe

PLEASE INDICATE WHICH PROGRAM THIS REFERRAL IS DIRECTED TO. Each program requires a separate referral.
ONLY check boxes available for requested program (i.e. urgent/elective only available in PASE)

☐ **Adult Outpatient Program (AOP)** **Telephone: 705-876-5028 Fax: 705-876-5013**

☐ Psychotherapy Services

☐ Psychiatric Consultation (Assessment and Treatment Recommendation)

☐ **Family & Youth Clinic** **Telephone: 705-876-5114 Fax: 705-876-5040**

☐ Family & Youth Clinic (FYC) ☐ Eating Disorders ☐ Urgent Care Clinic

If parents separated, give name and telephone for both:

Name: _____ Phone #: _____

Name: _____ Phone #: _____

☐ **Metabolic Clinic (AOP/PATC)** **Telephone: 705-876-5071 Fax: 705-876-5013**

Medication: _____ Prescriber: _____ Coverage: ☐ ODSP ☐ Private: _____

*For patients without primary care provider

☐ **LYNX Early Psychosis Intervention Program (EPI)** **Telephone: 705-876-5071 Fax: 705-876-5013**

☐ LYNX Early Psychosis Intervention Program (EPI)

Experiencing first possible break/symptoms of psychosis and aged 14 – 35 years

☐ **Psychosis Assessment and Treatment Clinic (PATC)** *(formerly Schizophrenia clinic)* **Telephone: 705-876-5071 Fax: 705-876-5013**

☐ Psychiatry ☐ Psychosocial Programs ☐ Clinical case management

☐ **Psychiatric Assessment Services for the Elderly (PASE) (Over age 65 years)** **Telephone: 705-876-5076 Fax: 705-876-5160**

☐ Urgent ☐ Elective ***Please include medical work up & reports**

CURRENT MEDICATIONS (Psychiatric) attach additional information if needed

Medication	Dose / Frequency	Response & Adverse Effects

PAST MEDICATIONS (Psychiatric)

Medication	Dose / Frequency	Response & Adverse Effects
Allergies:		

Past Psychiatric Assessments or Therapies: ☐ Yes ☐ No ☐ Documents attached to referral form

Please note, in order to process referral request any previous psychiatric assessments or therapy reports/documents must be attached to referral form

Practioner: _____ Date (DD/MM/YYYY): _____

Practioner: _____ Date (DD/MM/YYYY): _____

If your patient is in crisis and at imminent risk of self harm or suicide please direct the patient to the PRHC Emergency Department for assessment by the Crisis Response Team. You may also want to provide your patient with the suicide crisis helpline, 9-8-8, a safe space to talk, 24 hours a day, every day of the year.

1. Suicidality Ideation: ☐ No ☐ Active ☐ Passive Plan: ☐ No ☐ Yes Attempts: _____ Date of last attempt (DD/MM/YYYY): _____ Lethality of attempts: ☐ Low ☐ Moderate ☐ High	7. Cognitive functioning Developmentally Impaired? ☐ Yes ☐ No
2. Harmful Behaviour ☐ Current ☐ Past ☐ Unknown Toward self? ☐ No ☐ Yes Explain:	8. Previous mental health history ☐ Attach reports *(including FHT mental health therapists)* Presenting Problem (Dates/Hospitalized?)
3. Aggressive Behaviour ☐ Current ☐ Past ☐ Unknown Toward others? ☐ No ☐ Yes Explain:	9. Family Psychiatric History ☐ Yes ☐ No
4. Trauma History ☐ Current ☐ Past ☐ Unknown	10. Addictions/Substance Use (alcohol, drug, gambling, other) ☐ Current Use ☐ Past Use Type/Quantity/Frequency:
5. Family Issues	11. Legal Charges/Involvement ☐ No ☐ Yes Describe: 12. Referrals/waitlisted for other services? ☐ No ☐ Yes
6. Medical Issues	13. Other involved care providers: (GP, NP, Psych, CMHA, FHT Mental Health therapist, CCAC, etc.)

OFFICE USE ONLY

Date client called (DD/MM/YYYY): _____ 30 day expiry date (DD/MM/YYYY): _____

Booked with: _____

Appointment date (DD/MM/YYYY): _____ Time: _____ Method of contact: _____ ☐ Cancelled ☐ DNA

Appointment date (DD/MM/YYYY): _____ Time: _____ Method of contact: _____ ☐ Cancelled ☐ DNA