



596 Davis Drive
Newmarket, ON L3Y 2P9

Mental Health Program – TEL. (905) 895-4521, ext. 2666
FAX: (905) 830-5987

Health Record #: _____ Complete or place barcoded patient label here
 Patient Name: *(Print first, last)* _____
 DOB: dd / mm / yy Age: _____ Female Male
 OHIP #: _____ Version Code: _____
 Account #: _____ Date of Admission: dd / mm / yy

Adult Out-patient Referral/Psychiatric Consult Request Date of Referral: dd / mm / yy

Please print clearly and include any relevant medical reports, medication sheet, psychological reports, and copies of previous psychiatric consultations or discharge summaries. For specific program information and criteria please refer to Southlake Regional Health Centre Mental Health website, www.southlakeregional.org. **INCOMPLETE REFERRALS WILL NOT BE PROCESSED.**

This referral is indicated for: ECT *Specify: _____* Psychiatric Consult
 Brief Therapy Clinic: Individual / Group / Couple Day Program: Wellness / Recovery Discharge Clinic
 Adult Crisis Program (Urgent Clinic) Schizophrenia Clinic MOM (Mothers Out-patient Mental Health Clinic)

CLIENT/PATIENT INFORMATION

Name: *(print first, last)* _____ **Date of Birth:** dd / mm / yy _____

Address: Street Number + Name _____ Apartment _____ City _____ Province _____ Postal Code _____

Contact Number: _____ OK to call – OK to leave message: on voicemail with person

Alternate Number: _____ OK to call – OK to leave message: on voicemail with person

Sex: Male Female **Health Card Number:** _____ **Version Code:** _____

Name of Emergency Contact: *(print first, last)* _____

Relationship to Patient: _____

Contact Number: _____ OK to call – OK to leave message: on voicemail with person

Alternate Number: _____ OK to call – OK to leave message: on voicemail with person

RISK ISSUES

ANY HISTORY AS FOLLOWS?	YES	NO	IF YES, WHEN?	COMMENTS
Criminal Charges	<input type="checkbox"/>	<input type="checkbox"/>		
Violent Behaviour	<input type="checkbox"/>	<input type="checkbox"/>		
Suicidal Attempts	<input type="checkbox"/>	<input type="checkbox"/>		
Other Self Harm Behaviour	<input type="checkbox"/>	<input type="checkbox"/>		

CURRENT MEDICATIONS *(Psychiatric and Non-Psychiatric)* Please attach/or fax Southlake physician order sheet and/or prescription

MEDICATION	DOSE/FREQUENCY/ROUTE	SCRIPT ATTACHED	COMMENTS
		<input type="checkbox"/>	
		<input type="checkbox"/>	
		<input type="checkbox"/>	

For Injectable Medication: Date Last Given: dd / mm / yy Next Date Due: dd / mm / yy

How the medications are funded: ODSP ODB Private Insurance Self-Pay
 Drug Card Number: _____ *(attach copy or contact information for client's pharmacy)*





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Adult Out-patient Referral/Psychiatric Consult Request

CURRENT AND PAST PSYCHOTHERAPIES OR OTHER THERAPIES		
THERAPY	WHEN/DURATION	OUTCOME
Allergies: _____ Relevant Medical History – <i>Typed consult or history notes attached:</i> <input type="checkbox"/> No <input type="checkbox"/> Yes _____ Diagnosis and Psychiatric Presentation: _____ _____ Is there any legal or forensic aspect to this referral? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>(specify)</i> _____ _____ Is this client/patient involved in current/pending compensation/insurance claims? <input type="checkbox"/> No <input type="checkbox"/> Yes		
WE DO NOT ACCEPT REFERRALS PRIMARILY DEALING WITH COMPENSATION/INSURANCE ISSUES OR COURT ORDERED TREATMENT.		
REFERRING SOURCE INFORMATION		
Referred by: <i>(Check ✓ one)</i> <input type="checkbox"/> Family Doctor <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Southlake Program <input type="checkbox"/> Other <i>(specify)</i> _____ Reason For Referral: _____ _____ _____		
Referring Name: <i>(print first, last)</i>		Signature:
Phone Number:	Fax Number:	Email:
Name of Family Doctor: <i>(print first, last)</i>		Phone Number:
THIS SECTION ONLY TO BE COMPLETED BY SOUTHLAKE OUT-PATIENT PROGRAM STAFF		
Date Received: <u>dd</u> / <u>mm</u> / <u>yy</u>		Contacted: <input type="checkbox"/> No <input type="checkbox"/> Yes
Intake Date: <u>dd</u> / <u>mm</u> / <u>yy</u>		Referral Declined: <input type="checkbox"/> By client <input type="checkbox"/> By program
Comment:		
Staff Name: <i>(print first, last)</i>		Designation:
Staff Signature:		Date: <u>dd</u> / <u>mm</u> / <u>yy</u> Time: _____