SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9

Mental Health Program – Phone: 905-895-4521, ext. 5318
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

Rapid Assessment for Psychopharmacologic Treatment (RAPT) Referral Form

The Rapid Assessment for Psychopharmacologic Treatment (RAPT) Clinic offers consultation for Mental Health patients under the care of a family doctor who would benefit from psychiatric medication review.

Referrals can be accepted from Family Doctors affiliated with Southlake Regional Health Centre. Patients must be receiving regular follow-up with the referring Family Doctor, and must meet the RAPT referral criteria as listed below.

The clinic will offer timely psychiatric consultation and limited short term follow-up (maximum two months duration) with a Psychiatrist and RAPT Nurse who will liaise with the patient's Family Doctor to provide assessment and treatment recommendations. The RAPT Clinic does not offer long term follow-up, although it can help with community linkages for the follow-up.

CLIENT/PATIENT INFORMATION

INCOMPLETE FORMS WILL NOT BE PROCESSED

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

Patient Address: Street Number + Name | Apartment | City | Province | Postal Code

Home Phone Number: ❑ can call this number ❑ can leave messages ❑ on voicemail ❑ with person

Cell Phone Number: ❑ can call this number ❑ can leave messages ❑ on voicemail ❑ with person

Sex: ❑ Male ❑ Female | **Health Card #:** | **Version Code:**

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

Relationship to Patient: | **Phone Number:**

REFERRAL INFORMATION

Psychiatric Diagnosis: _____

Reason for Referral: _____

Patient is presenting with a primary diagnosis of: *(check all that apply)*

❑ Anxiety disorder: *(please specify)* _____

❑ Mood disorder: ❑ Depression ❑ Bipolar Disorder _____

❑ Schizophrenia: _____

Ensure RAPT criteria is met using check boxes

❑ Patient is age 18-65 and DOES NOT have an existing psychiatrist

❑ Patient has a need for medication adjustment and short term follow up, is not seeking psychotherapy or long term care

❑ Patient does not need hospitalization (i.e., is not acutely suicidal)

❑ **Patient must be registered and regularly followed by referring family Physician or Nurse**

We are NOT able to accept referrals for assessments/treatment where concerns are related principally to:

- Adult ADHD
- Anger management
- Autism Spectrum Disorders
- Chronic pain
- Developmental delay
- Eating disorder
- Primary Substance Abuse
- Relationship counselling
- Primary Issues R/T Personality Disorder *(i.e. anger management)*

RAPT Clinic does not provide assessments or documentation for legal, insurance, CAS, or WSIB purposes.

SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9

Mental Health Program – Phone: 905-895-4521, ext. 5318
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

Rapid Assessment for Psychopharmacologic Treatment (RAPT) Referral Form

PAST PSYCHIATRIC/ADDICTIONS HOSPITALIZATIONS (attach discharge summaries, if available)

Facility	Dates	Reason	Duration

CURRENT COMMUNITY AGENCIES/SUPPORT Please check all that apply *(support currently receiving)*

❑ CMHA ❑ Loft/Crosslinks (housing support) ❑ Addiction Services York Region ❑ Therapist/Counselor ❑ Support group
❑ Brief Therapy Clinic ❑ Urgent Clinic ❑ Other Southlake Services: *(please specify)* _____

RELEVANT MEDICAL/MENTAL HEALTH HISTORY

Past Mental Health History/Substance Abuse History (attach previous consults, reports, relevant lab reports):

_____

_____

_____

_____

Relevant Medical History: _____

_____

_____

_____

_____

Allergies: _____

Relevant lab results: ❑ Yes, attached ❑ Yes, faxed ❑ No

SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9

Mental Health Program – Phone: 905-895-4521, ext. 5318
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

Rapid Assessment for Psychopharmacologic Treatment (RAPT) Referral Form

CURRENT MEDICATION *(Psychiatric and Non-Psychiatric)*

Name of Drug	Dose	Date of Trial	Duration of Trial	Response (Efficacy and Side Effects)

PREVIOUS MEDICATIONS *(Trials)*

MEDICATION	DOSE/FREQUENCY/ROUTE	START DATE	DATE OF LAST DOSE	RESPONSE/ADVERSE EVENTS

BY SIGNING THIS FORM, I CONFIRM THAT THIS PATIENT IS AWARE OF THIS REFERRAL

Referred by: *Check (✔) one* ❑ Family Physician ❑ Nurse Practitioner

Name of Family Practice Clinic:

Referring Name: *(print first, last)* **Billing #:**

Signature: **Date of Referral:** dd / mm / yy

Phone Number: **Fax Number:**

SOUTHLAKE STAFF to Complete – Date Received: dd / mm / yy **Contacted:** ❑ No ❑ Yes **Date:** dd / mm / yy

Referral Declined: ❑ By client ❑ By program

Comment: _____

Staff Name: *(print first, last)* **Designation:**

Signature: **Date:** dd / mm / yy **Time:** _____

INCOMPLETE FORMS WILL NOT BE PROCESSED

SL1406_15 (08/18) "Adult Outpatient Mental Health" Review (08/21)