

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 Health Mental Health website, www.southlake.ca. **INCOMPLETE REFERRALS WILL NOT BE PROCESSED.**

This referral is indicated for:

- Electroconvulsive Therapy (ECT) Psychiatric Consult (one time)
 MOM (Mothers Out-patient Mental Health Clinic): Currently Pregnant / Postpartum less than 9 months

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 at Birth: Male Female Intersex Gender: _____ Pronouns: _____

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/Violent Behaviour	<input type="checkbox"/>	<input type="checkbox"/>		
Suicidal Attempts/Self Harm Behaviour	<input type="checkbox"/>	<input type="checkbox"/>		

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

MEDICATION	DOSE/FREQUENCY/ROUTE	COMMENTS

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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OHIP #: _____	Version Code: _____
Account #: _____	Date of Admission: <u>dd</u> / <u>mm</u> / <u>yy</u> _____

Adult Out-patient Referral/Psychiatric Consult Request

CURRENT AND PAST PSYCHOTHERAPIES OR OTHER THERAPIES		
THERAPY	WHEN/DURATION	OUTCOME
Allergies: _____ Relevant Medical History – Typed consult or history notes attached: <input type="checkbox"/> No <input type="checkbox"/> Yes Diagnosis and Psychiatric Presentation: <input type="checkbox"/> MDD <input type="checkbox"/> GAD <input type="checkbox"/> PTSD <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Bipolar Mood Disorder <input type="checkbox"/> Substance Use Disorder: <input type="radio"/> Alcohol / <input type="radio"/> Cannabis / <input type="radio"/> Cocaine / <input type="radio"/> Other _____ <input type="checkbox"/> Personality Disorder <input type="checkbox"/> Other _____ 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/litigation? <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: <input type="checkbox"/> Diagnostic Impression <input type="checkbox"/> Medication Recommendation <input type="checkbox"/> Other <i>(specify)</i> _____		
Referring Name: <i>(print first, last)</i> _____		Signature: _____
Phone Number: _____	Fax Number: _____	Billing #: _____
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: _____