

Health Record #: _____	Complete or place barcoded patient label here
Patient Name: <i>(Print first, last)</i> _____	
DOB: <u>dd</u> / <u>mm</u> / <u>yy</u>	Age: _____ <input type="checkbox"/> Female <input type="checkbox"/> Male
OHIP #: _____	Version Code: _____
Account #: _____	Date of Admission: <u>dd</u> / <u>mm</u> / <u>yy</u>

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 Health. 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: <i>(print first, last)</i> _____				Date of Birth: <u>dd</u> / <u>mm</u> / <u>yy</u>	
Patient Address: Street Number + Name _____		Apartment _____	City _____	Province _____	Postal Code _____
Home Phone Number: _____		<input type="checkbox"/> can call this number	<input type="checkbox"/> can leave messages	<input type="checkbox"/> on voicemail	<input type="checkbox"/> with person
Cell Phone Number: _____		<input type="checkbox"/> can call this number	<input type="checkbox"/> can leave messages	<input type="checkbox"/> on voicemail	<input type="checkbox"/> with person
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Health Card #: _____			Version Code: _____	
Name of Emergency Contact: <i>(print first, last)</i> _____					
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.



596 Davis Drive
Newmarket, ON L3Y 2P9

Mental Health Program – Phone: 905-895-4521, ext. 5318
Fax: 905-830-5987

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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

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CURRENT MEDICATION <i>(Psychiatric and Non-Psychiatric)</i>				
Name of Drug	Dose	Date of Trial	Duration of Trial	Response (Efficacy and Side Effects)

PREVIOUS MEDICATIONS <i>(Trials)</i>				
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: <i>Check (✓) one</i> <input type="checkbox"/> Family Physician <input type="checkbox"/> Nurse Practitioner	
Name of Family Practice Clinic: _____	
Referring Name: <i>(print first, last)</i> _____	Billing #: _____
Signature: _____	Date of Referral: <u>dd</u> / <u>mm</u> / <u>yy</u>
Phone Number: _____	Fax Number: _____
SOUTHLAKE STAFF to Complete – Date Received: <u>dd</u> / <u>mm</u> / <u>yy</u> Contacted: <input type="checkbox"/> No <input type="checkbox"/> Yes 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: _____
Signature: _____	Date: <u>dd</u> / <u>mm</u> / <u>yy</u> Time: _____