

## Adult Outpatient Referral Form – Mental Health and Addictions

Please **DO NOT** Fax this cover sheet with the referral

### For Referring Providers

- Niagara Health Outpatient Mental Health and Addictions Program offers evidence-based assessments / treatment for adults.
- A physician / nurse practitioner referral is required for most services.
- Niagara Health **does not** offer:
  - Individual counselling
  - Grief / bereavement services
  - Anger management services
  - Assessments for complex dual diagnosis
  - Assessment, treatment and/or rehabilitation for acquired brain injury (ABI), traumatic brain injury (TBI) or concussion
  - Parenting capacity / custody access or forensic assessments
  - Assessments for the Ontario Disability Support Program (ODSP) or insurance providers / workplace
  - Assessment for legal purposes (criminal or civil)

### For Your Client

- Please ensure your client is aware that the referral is being made.
- A mental health clinician will review each referral.
- Two attempts will be made to call the client. A letter will be sent to the referring provider if no contact is made.
- Some services may have a waitlist and clients will be informed of this when contact is made.
- Please provide the **While You Wait Resources** to assist the client in getting the most out of the wait time by checking out the online and self – directed resources.

### How to Refer to Outpatient Mental Health and Addiction Services

- Fax the completed referral form to **905-704-4420**.
- Pages 1 and 2 must be completed in full for all referrals.
- Additional Required Information form must be completed for all Medication Clinic (Page 3), ECT (Page 4) and rTMS (Page 5) referrals.
- **AVOID DELAYS** – incomplete referrals delay care for your client. Ensure that all sections of the referral form are complete and all necessary information is included. All incomplete referral forms will be returned to the referring provider.
- For any enquiries, please call **905-378-4647 Extension 49613**.

### Psychiatric Consultation (CAPS):

- **Inclusion Criteria:**
  - **One-time psychiatric consultation** is available with the understanding that the referring physician is responsible for the implementation of recommendations.
  - CAPS does not provide "second opinion" consults.
  - For conditions related to depressive and anxiety disorders, there must be evidence of two medication trials within the current episode of illness.
  - For conditions related to depression a PHQ-9 (completed by client) must be included with the referral.
  - For conditions related to anxiety a GAD7 (completed by client) must be included with the referral.
  - For first episode psychotic disorders, please refer to Niagara Region First Episode Psychosis Program, if appropriate

### Rapid Access Addiction Medicine (RAAM)

- **Inclusion Criteria:**
  - Assessments and treatments for substance use problems such as alcohol, opioids, cocaine, benzodiazepines, and cannabis
  - Medications may be prescribed for substance use, withdrawal, and craving, opioid agonist treatment with methadone and buprenorphine
  - Any questions, please call **905-378-4647 Extension 49463**.



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Pages 1 and 2 must be completed in full for all referrals (incomplete forms will not be processed)  
Additional Required Information Form must be completed for all referrals Medication Clinic (Pg. 3), ECT (Pg. 4), rTMS (Pg. 5)  
Please fax all referrals to 905-704-4420. For any enquiries, please call Intake at 905-378-4647 Ext. 49613

### SECTION A: Client Information

Is client aware of referral?  Yes  No Is client at risk to self/others?  Yes  No

Client Name: \_\_\_\_\_ HC with Version Code: \_\_\_\_\_

Address: \_\_\_\_\_ City/Town: \_\_\_\_\_

Telephone: (H) \_\_\_\_\_ leave message  Y  N (C) \_\_\_\_\_ leave message  Y  N

**Must Include E-mail:** \_\_\_\_\_

All our services are provided virtually. If unable to participate virtually and/or without an e-mail, please provide details: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ (dd/mm/yyyy) Birth Gender:  Male  Female Identified Gender: \_\_\_\_\_

English primary language?  Y  N Language of preference? \_\_\_\_\_

Require Interpreter?  Y – language \_\_\_\_\_  N Identify as First Nations/Indigenous?  Y  N

Name of Family Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

### SECTION B: (if referring to multiple programs, please number priority of services)

**Program Requested:**

**Reason for Referral:**

# _____ CAPS – Centralized Access to Psychiatric Services	<input type="checkbox"/> Assessment <input type="checkbox"/> Diagnostic Clarifications <input type="checkbox"/> PHQ-9 attached	<input type="checkbox"/> Medication Recommendations <input type="checkbox"/> Medication trials included <input type="checkbox"/> GAD7 attached
# _____ Urgent Access NP (NH ED Physician Only)	<input type="checkbox"/> Assessment <input type="checkbox"/> Diagnostic Clarifications	<input type="checkbox"/> Medication Recommendations
# _____ RAAM – Rapid Access to Addiction Medicine	<input type="checkbox"/> Alcohol <input type="checkbox"/> Opiates	<input type="checkbox"/> Other:
# _____ Seniors Mental Health (Physician/NP referral only) Contact Person for Appointment: _____ Relationship: _____ Phone Number: _____ INCLUDE ALL RECENT LAB WORK, CT/MRI HEAD, BMD, RELEVANT CONSULTATIONS	<input type="checkbox"/> Cognitive Decline <input type="checkbox"/> New Mental Health	<input type="checkbox"/> Diagnostic Clarifications <input type="checkbox"/> Medication Recommendations
# _____ Adult Group Therapy (check one diagnosis)	<input type="checkbox"/> Anxiety <input type="checkbox"/> Bipolar <input type="checkbox"/> Depression	<input type="checkbox"/> Emotion Dysregulation <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Concurrent/Other:
# _____ Day Hospital (3 days per week <u>SCS</u> only)	<input type="checkbox"/> Complex mental health ONLY mood, anxiety or thought disorders <input type="checkbox"/> Impairments with daily functioning	
# _____ STAR – Skills Training And Recovery (formerly GEM)	<b>Must meet ALL the following criteria</b> <input type="checkbox"/> History of trauma <input type="checkbox"/> Severe emotion dysregulation <input type="checkbox"/> Participate mixed gender groups <input type="checkbox"/> Current trauma symptoms Impedes daily functioning	

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## Adult Outpatient Referral Form Mental Health and Addictions

### SECTION B: (Continued)

Program Requested:

Reason for Referral:

# \_\_\_ Medication Clinic – to complete this referral **you must go to page 3** to input additional required Information

# \_\_\_ ECT – Electroconvulsive Therapy – to complete this referral, **you must also go to Page 4** for additional input

# \_\_\_ rTMS – Repetitive Transcranial Magnetic Stimulation – to complete this referral, **you must also go to Page 5**

# \_\_\_ CTO \_Community Treatment Order

**(Community / outpatient referrals only)**

Assess Suitability

30+ days inpatient mental health admission within past 3 years

2 lengthy inpatient mental health admissions within past 3 years

Previous CTO in the past

### SECTION C: PRESENTING SYMPTOMS:

Current challenges / concerns: \_\_\_\_\_

Previous / Current Mental Health Diagnosis (**must indicate mild / moderate / severe** as per PHQ-9):  attached PHQ-9

Previous / Current Medical Diagnosis: \_\_\_\_\_

Medication (both psychiatric and non-psychiatric medication)  Medication List attached / additional attached

Medication	Current	Dose	Frequency	Response and Adverse Effects
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			

Allergies: \_\_\_\_\_

### SECTION D: RISK

Please complete the following chart:

Problem	Present (within past 6 months)		Past (6 months or more)		Denied	Unknown
	Yes	No	Yes	No		
Alcohol / Substance Use						
Violent Behaviour						
Suicidal Ideation						
Suicidal Attempts						
Self-Harming Behaviour						

**If you have concerns regarding any immediate risk issues, please contact COAST or call 911.**

**We do not provide crisis response services.**

If answered yes above, please identify / report concerns: \_\_\_\_\_

Completed by (print & sign): \_\_\_\_\_

MD/NP Billing #: \_\_\_\_\_

Referring Unit (Internal Only): \_\_\_\_\_

Referring Source Fax: \_\_\_\_\_

Referring Source Phone: \_\_\_\_\_

Referral Date: \_\_\_\_\_ (dd/mm/yyyy)



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**Additional Required Information – Medication Clinic:**  
For any enquiries, please call Intake at 905-378-4647 Ext. 49613

NEW Niagara Health Medication Client **OR**  ACTIVE Niagara Health Medication Client

Name of NH Psychiatrist referring:	
<b>MUST HAVE</b> Name of Psychiatrist providing follow up:	<input type="checkbox"/> referent will support Medication Clinic <b>OR</b> _____
Name and Dosage of Prescribed Long Acting Medication:	
<input type="checkbox"/> LAI: <input type="checkbox"/> Clozaril® (clozapine) New Client: <input type="checkbox"/> CSAN #: _____ <input type="checkbox"/> attached CSAN Enrollment Form <input type="checkbox"/> Generic Brand / Clozaril® <input type="checkbox"/> Monitoring Portal: _____	<input type="checkbox"/> Attached <u>discharge</u> prescription with # of refills for Medication Clinic Use (small orange)
Next dosage due date / dosage amount:	
Frequency of medication given	
Medication Start Date (dd/mm/yyyy):	
Date Medication / Injection Last Given (dd/mm/yyyy):	
Attached separate prescription for LAI / Clozaril® and these medications say "Do Not Fill" on discharge BPMH	<input type="checkbox"/> Yes
Clozaril® in client's hand at discharge from inpatient unit?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
How often is blood work to be completed for Clozaril®?	<input type="checkbox"/> Not Applicable
Follow Up Appointment for Outpatient Medication Clinic?	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No
Follow Up Appointment Made for Psychiatrist / NP?	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No
Client Aware of Medication Clinic Location?	<input type="checkbox"/> Yes <input type="checkbox"/> No
How is client paying for Medication? (ODSP, CPP, Trillium)	<input type="checkbox"/> Attached copy of private insurance medication plan _____
Pharmacy where drug card being used:	
Client has transportation to Medication Clinic?	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No
Who is bringing client to appointment at clinic?	<input type="checkbox"/> Client <input type="checkbox"/> Name/Contact #:
Additional Contact Person Name and Number?	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No
Referring Unit (Internal Only):	CN (print/sign – Internal Only):

Rev. 12/2021 (v4)



REF41

**Adult Outpatient Referral Form  
Mental Health and Addictions**

**Additional Required Information – ECT – Electroconvulsive Therapy:**

Clients **MUST** have had a psychiatric / mental health assessment by GP, psychiatrist or NP within past 6 months.  
If not, please refer to CAPS for assessment and diagnostic clarification

**Please fax all referrals to 905-704-4420. For any enquiries, please call Intake at 905-378-4647 Ext. 49613**

Treatment – resistant depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Major depressive disorder with psychotic feature	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Unable to tolerate antidepressant medications	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mania non-responsive to pharmacological treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Acutely suicidal	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Malnourished / dehydrated, rapidly deteriorating physical status	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Schizophrenia – antipsychotic non-responsive	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prior ECT favourable response	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other indication for ECT	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Previous ECT details (name of institution, describe the type of ECT, if bilateral / unilateral, number of treatments, response and any unusual side effects).

General Anaesthesia History: any complications with general anaesthetic?  Yes  No

Consent: Is the person competent to consent to treatment?  Yes  No

If "No" who is the substitute decision maker / contact number? \_\_\_\_\_

**Lab / Diagnostic Tests must be sent with this referral:** CBC, TSH, B12, Sodium, Potassium, Chloride, Ca, Mg, Phosphate, AST, ALT, GGT, ALP, Bilirubin, BUN, Creatinine, Fe, Urinalysis, EKG and any other relevant tests / procedures / consultation notes

**Internal Use Only:**

**Anaesthesia Consult:** \_\_\_\_\_ **Physician Consult:** \_\_\_\_\_ **First ECT:** \_\_\_\_\_



REF41

## Adult Outpatient Referral Form Mental Health and Addictions

**Additional Required Information – rTMS – Repetitive Transcranial Magnetic Stimulation:**  
 Clients **MUST** have had a psychiatric / mental health assessment by psychiatrist or NP within past 6 months.  
 If not, please refer to CAPS for assessment and diagnostic clarification

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### Indications for rTMS:

Major depressive disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Please elaborate for each "Yes" indication</b>
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### Potential Contraindications for rTMS:

History of epileptic seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	
History of stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Family history of epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	
History of syncopal episodes	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Head trauma with loss of consciousness	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cardiac disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cardiac arrhythmia	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Implanted cardiac pacemaker or defibrillator	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Implanted DBS or other neurostimulator	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cochlear implant	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Medication infusion device	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Aneurysm clip or coils	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Metallic implant or other foreign body	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Ever have metal fragments in eye	<input type="checkbox"/> Yes <input type="checkbox"/> No	
History of metal work	<input type="checkbox"/> Yes <input type="checkbox"/> No	
History of spinal surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Impairment of vulnerability of hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	
History / current alcohol use	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pregnancy	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Chronic neck / back pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Internal Use Only:**     Previous rTMS     Previous ECT



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