niagarahealth
Extraordinary Caring. Every Person. Every Time.

Adult Outpatient Referral Form
Mental Health and Addictions

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	☐ Assessment ☐ Diagnostic Clarifications	☐ Medication Recommendations
#____ Urgent Access NP **(NH ED Physician Only)**	☐ Assessment ☐ Diagnostic Clarifications	☐ Medication Recommendations
#____ RAAM − Rapid Access to Addiction Medicine	☐ Alcohol ☐ Opiates	☐ Other:
#____ Seniors Mental Health **(Physician/NP referral only)**	☐ Cognitive Decline ☐ New Mental Health	☐ Longstanding Mental Health

Contact Person for Appointment: _____

Relationship: _____ Phone Number: _____

INCLUDE ALL RECENT LAB WORK, CT/MRI HEAD, BMD, RELEVANT CONSULTATIONS

#____ Adult Group Therapy (check one diagnosis)	☐ Anxiety ☐ Bipolar ☐ Depression	☐ Emotion Dysregulation ☐ Schizophrenia ☐ Concurrent/Other:
#____ Day Hospital (3 days per week SCS only)	☐ Complex mental health ONLY mood, anxiety or thought disorders ☐ Impairments with daily functioning	
#____ STAR − Skills Training And Recovery (formerly GEM)	**Must meet ALL the following criteria** ☐ History of trauma ☐ Severe emotion dysregulation ☐ Participate mixed gender groups	☐ Current trauma symptoms Impedes daily functioning

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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: _____

_____

_____

Previous / Current Medication(s) / Dosages: ☐ attached medication list

_____

_____

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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