Pathstone Mental Health

Primary Care Referral Form

Our intake process will ensure your referral will be directed to the appropriate services **FAX: 905-688-0683**

Patient/Client's Personal Information

Name: Pref. Name:		Health Card Number :
Address :	City :	Postal Code
Telephone :	Cell :	Other :
DOB :	Age :	Gender :
Parent's Name :	Parent's Name :	
Resides with : (Choose)	Custody Type: N/A ☐ Joint ☐ Sole ☐	
Family Physician :	Telephone : - -	
Psychiatrist :	Telephone : - -	

Referral Information

Referred by :	Date :	Physician's Billing # :

Risks	Current	Previous	Within the last year
Thoughts of suicide:	☐	☐	☐
Suicide attempts:	☐	☐	☐
Thoughts of self-harm:	☐	☐	☐
Engaged in self-harm:	☐	☐	☐

	Current	Previous	Within the last year
Thoughts of harm to others:	☐	☐	☐
Engaged in harm to others:	☐	☐	☐
Substance/alcohol misuse:	☐	☐	☐
High risk actions:	☐	☐	☐
Police/legal involvement:	☐	☐	☐

Reason for Request (Required):

Service(s) Requested:

☐ **Counselling/Therapy**

☐ **Psychiatric Consult (for Diagnostic Clarification and/or Medication follow-up)**

Medication **List of Current Medications-Please print clearly**

Name of Medication	Dosage	Frequency
Allergies		

Consent and Agreement

I/, WE THE UNDERSIGNED AGREE TO THE EXCHANGE OF PERSONAL HEALTH INFORMATION BETWEEN AND PATHSTONE MENTAL HEALTH. I FURTHER AGREE TO THE PERSONAL HEALTH INFORMATION EXCHANGE BETWEEN PATHSONE MENTAL HEALTH AND NIAGARA HEALTH BE COLLECTED, USED, OR DISCLOSED FOR THE PURPOSE OF REFERRAL, TREATMENT PLANNING, COORDINATION AND FOLLOW UP SERVICES/SUPPORTS. I ALSO AGREE TO A SOCIAL WORKER CALLING ME FOR THE PURPOSE OF COMPLETING AN INTAKE.

SIGNATURE _____ DATE _____