

## 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), and ECT (Page 4) 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, two medication trials within the current episode of illness is recommended before referral.
  - For conditions related to depression a PHQ-9 (completed by client) is recommended to 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)

All RAAM patients can be referred to the following walk-in services:  
 St. Catharines at 264 Welland Avenue – Mondays 9:00 – 11:00 a.m. / Wednesdays 1:00 – 3:00 p.m.  
 St. Catharines Marotta Family Hospital – Thursdays 9:00 – 11:00 a.m.  
 Niagara Falls Hospital – Wednesdays 9:00 – 11:00 a.m.  
 Welland Hospital – Fridays 9:00 – 11:00 a.m.

Contact **905-378-4647 Extension 49463** for assistance



## Adult Outpatient Referral Form Mental Health and Addictions

### 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: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

**OR** Other Coverage (copy attached)

Address: \_\_\_\_\_

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

Contact Number: \_\_\_\_\_

Can a message be left at this number? ☐ Yes ☐ No

Can we use e-mail for appointment communication? ☐ Y E-mail Address: \_\_\_\_\_ ☐ No

Services may be provided virtually – E-mail Address: \_\_\_\_\_ ☐ Same as above?

Date of Birth: \_\_\_\_\_ (dd/mm/yyyy) Identify as First Nations/Indigenous? ☐ Y ☐ N

Birth Gender: ☐ Male ☐ Female ☐ Prefer not to Answer ☐ Prefer to Self-Identify \_\_\_\_\_

Preferred language? ☐ English ☐ Other: \_\_\_\_\_ Require Interpreter? ☐ Y language \_\_\_\_\_ ☐ N

Emergency Contact: Relationship \_\_\_\_\_ Contact #: \_\_\_\_\_

Indicate all that apply: ☐ Cognitive Impairment ☐ Hearing Impairment ☐ Visual Impairment ☐ Support Worker

☐ Mobility / Fall Risk ☐ Bariatric ☐ Sensory ☐ Therapy / Service Animal ☐ Other: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_ 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 (Physician/NP referral only)	<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
# _____ 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	<input type="checkbox"/> Complex mental health ONLY mood, anxiety or thought disorders <input type="checkbox"/> Impairments with daily functioning
# _____ STAR – Skills Training And Recovery	<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
# _____ Medication Clinic to complete this referral <b>you must go to page 3</b> to input additional required information	
# _____ ECT Electroconvulsive Therapy to complete this referral, <b>you must go to Page 4</b> for additional input	
# _____ CTO Community Treatment Order (Community referrals only)	Assess suitability: <input type="checkbox"/> 30+ days inpatient mental health admission within past 3 years <input type="checkbox"/> 2 lengthy inpatient mental health admissions within past 3 years <input type="checkbox"/> previous CTO in the past

Rev. 05/2025(v9)



REF41

**Chart Copy – Do Not Destroy**

## Adult Outpatient Referral Form Mental Health and Addictions

### SECTION C: PRESENTING SYMPTOMS:

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

\_\_\_\_\_

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

\_\_\_\_\_

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

\_\_\_\_\_

Medication/Supplements (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			
Medication Trials: <input type="checkbox"/> No <input type="checkbox"/> Yes (fill out below) OR <input type="checkbox"/> Client declined trials				
Medication Trials	Current	Dose	Frequency	Response and Adverse Effect
	<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:

	Within past 3 months		More than 3 months		Not Applicable	Details
	Yes	No	Yes	No		
Alcohol / Substance Use						
Physically Violent						
Suicidal Ideation						
Suicidal Attempts						
Self-Harming						
Homicidal Threat/Ideation						
Homeless / Risk Of						

Concerns regarding any immediate risk issues, please contact COAST or call 911. We do not provide crisis response services.

Primary Care Referring (print & sign): \_\_\_\_\_ Billing #: \_\_\_\_\_

Referring Number: \_\_\_\_\_ Referring Fax: \_\_\_\_\_

Referring Source Phone: \_\_\_\_\_ Referral Date: \_\_\_\_\_ (dd/mm/yyyy)



REF41

Chart Copy – Do Not Destroy

## Adult Outpatient Referral Form Mental Health and Addictions

### Additional Required Information – Medication Clinic:

For any enquiries, please call Intake at 905-378-4647 Ext. 49613

Name and Current Dosage of Prescribed Medication:

☐ LAI:

☐ Clozaril® (clozapine)

New Client: ☐ CSAN #: \_\_\_\_\_

☐ attached CSAN Enrollment Form

☐ Generic Brand / Clozaril®

☐ Monitoring Portal: \_\_\_\_\_

Next dosage due date / dosage amount:

Frequency of medication given

Medication Start Date (dd/mm/yyyy):

Date Medication / Injection Last Given (dd/mm/yyyy):

How often is blood work to be completed for Clozaril®?

☐ Not Applicable

Client Aware of Medication Clinic Location?

☐ Yes ☐ No

How is client paying for Medication? (ODSP, CPP, Trillium)

☐ Attached copy of private insurance medication plan

Pharmacy where drug card being used:

Client has transportation to Medication Clinic?

☐ Yes \_\_\_\_\_ ☐ No

Who is bringing client to appointment at clinic?

☐ Client  
☐ Name/Contact #: \_\_\_\_\_

Additional Contact Person Name and Number?

☐ Yes \_\_\_\_\_ ☐ No

Referring Physician

Billing Number



## 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

**Chart Copy – Do Not Destroy**