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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**

Client Name: ______________________________ HC with Version Code: ______________________________
Address: ______________________________ City/Town: ______________________________
Telephone: (H) ________________ leave message ☐ Y ☐ N (C) ________________ leave message ☐ Y ☐ N
Date of Birth: ________________ (dd/mm/yyyy) Birth Gender: ☐ Male ☐ Female Identified Gender: __________
Name of Family Physician: ______________________________ Phone Number: ______________________________
Psychiatrist: ______________________________ Phone Number: ______________________________

SECTION B: (if referring to multiple programs, please number priority of services)		
Program Requested:	**Reason for Referral:**	**Internal Use Only:**
☐ CAPS – Centralized Access to Psychiatric Services #____ **(physician/NP referral only)**	☐ Assessment ☐ Diagnostic Clarifications ☐ Medication Recommendations	Appt. Date: ________ Completed: ________ See Notes: ☐ Yes ☐ N/A
☐ Urgent Access Nurse Practitioner **(NH ED Physician Only)** #____	☐ Assessment ☐ Diagnostic Clarifications ☐ Medication Recommendations	Appt. Date: ________ Completed: ________ See Notes: ☐ Yes ☐ N/A
☐ RAAM – Rapid Access to Addiction Medicine #____	☐ Alcohol ☐ Opiates ☐ Other:	Appt. Date: ________ Completed: ________ See Notes: ☐ Yes ☐ N/A
☐ 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	☐ Cognitive Decline ☐ New Mental Health ☐ Longstanding Mental Health	Appt. Date: ________ Completed: ________ See Notes: ☐ Yes ☐ N/A
☐ WRICCP – Wellness Recovery Integrated Comprehensive Care Program #____	**Must meet ALL the following criteria:** ☐ Recent suicide attempt ☐ Recent / frequent ED / Admission Inpatient ☐ Acute phase of mental health illness ☐ Significant impact to functioning	Appt. Date: ________ Completed: ________ See Notes: ☐ Yes ☐ N/A
☐ Adult Group Therapy (check one) ☐ Depression ☐ Anxiety #____ ☐ Schizophrenia ☐ ADHD	☐ Bipolar ☐ Emotion Dysregulation ☐ Pain Control and Wellness	Appt. Date: ________ Completed: ________ See Notes: ☐ Yes ☐ N/A
☐ Day Hospital (3 days per week SCS only) #____	☐ Complex mental health ☐ Impairments with daily functioning	Appt. Date: ________ Completed: ________ See Notes: ☐ Yes ☐ N/A
☐ GEM – Guiding Emotions Mindfully (1.5 days per week SCS only) #____	☐ Severe emotion dysregulation ☐ History of trauma	Appt. Date: ________ Completed: ________ See Notes: ☐ Yes ☐ N/A
☐ Medication Clinic – to complete this referral **you must also go to page 3** to input additional required information #____		Appt. Date: ________ Completed: ________ See Notes: ☐ Yes ☐ N/A

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SECTION B: (Continued)

Program Requested:	Reason for Referral:	Internal Use Only:
☐ ECT – Electroconvulsive Therapy – to complete this referral, you must also go to Page 4 to input additional required information #____		Appt. Date: ______________ Completed: ______________ See Notes: ☐ Yes ☐ N/A
☐ rTMS – Repetitive Transcranial Magnetic Stimulation – to complete this referral, you must also go to Page 5 to input additional required information #____		Appt. Date: ______________ Completed: ______________ See Notes: ☐ Yes ☐ N/A
☐ CTO – Community Treatment Order #____	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	Appt. Date: ______________ Completed: ______________ See Notes: ☐ Yes ☐ N/A

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 answered yes above, please identify / report concerns: ____

____

Referring Source (print): ______________________ MD/NP Billing #: ______________________

Referring Source Phone: ______________________ Referring Source Fax: ______________________

Signature: ______________________ Referral Date: ______________________ (dd/mm/yyyy)

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Additional Required Information – Medication Clinic:

Please call Medication Clinic before submitting Referral Form 905–378–4647: Niagara Falls Ext. 53812
St. Catharines Ext. 46437 Welland Ext. 33402

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

Long Acting Injection (LAI):	
Name and Dosage of Prescribed Long Acting Medication:	
Medication Start Date:	
Date Injection Last Given:	
Follow Up Appointment for Outpatient Medication Clinic?	☐ Yes ☐ No
Follow Up Appointment Made for Psychiatrist / Nurse Practitioner?	☐ Yes ☐ No
Patient Aware of Medication Clinic Location?	☐ Yes ☐ No
Is Patient on Drug Plan?	☐ Yes ☐ No
Patient's Pharmacy where drug card being used?	
Clozaril® (clozapine):	**CSAN Number:**
Medication Start Date:	
Follow Up Appointment for Outpatient Medication Clinic	☐ Yes ☐ No
Follow Up Appointment Made for Psychiatrist?	☐ Yes ☐ No
Seperate Prescription written for Clozaril® (clozapine)?	☐ Yes ☐ No
Sufficient dose until next appointment in Medication Clinic	☐ Yes ☐ No
Deliver and fill prescription prior to Discharge?	☐ Yes ☐ No
Clozaril® (clozapine) Prescription given to patient?	☐ Yes ☐ No
Patient aware of Medication Clinic location?	☐ Yes ☐ No

Please send the following information for NH referrals only:

Completed referral form
Doctor's order
Prescription
Copy of CSAN Form 1
Clinical Pathway client dicharged on
Last CBC report
Client's history

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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	☐ Yes ☐ No
Major depressive disorder with psychotic feature	☐ Yes ☐ No
Unable to tolerate antidepressant medications	☐ Yes ☐ No
Mania non–responsive to pharmacological treatment	☐ Yes ☐ No
Acutely suicidal	☐ Yes ☐ No
Malnourished / dehydrated, rapidly deteriorating physical status	☐ Yes ☐ No
Schizophrenia – antipsychotic non–responsive	☐ Yes ☐ No
Prior ECT favourable response	☐ Yes ☐ No
Other indication for ECT	☐ Yes ☐ 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:** ________________

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Chart Copy – Do Not Destroy

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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

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

Indications for rTMS:

		Please elaborate for each "Yes" indication
Major depressive disorder	☐ Yes ☐ No	

Potential Contraindications for rTMS:

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

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

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