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Adult Outpatient Mental Health Referral Form

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 ECT, rTMS and Medication Clinic referrals
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: _____ Birth Gender: ☐Female ☐Male Identified Gender:_____
Name of Family Physician: _____ Phone number: _____
Psychiatrist: _____ Phone number: _____

SECTION B: Program Requested:	**Reason for Referral:**	**Internal Use Only:**
☐ CAPS - Centralized Access to Psychiatric Services / Consultation	☐ Assessment ☐ Diagnostic Clarification ☐ Medication Recommendation	Intake Date: _____ Completed: _____ See Notes: ☐Yes ☐N/A
☐ Urgent Access Nurse Practitioner **(NH ED physician only)**	☐ Assessment ☐ Diagnostic Clarification ☐ Medication Recommendation	Intake Date: _____ Completed: _____ See Notes: ☐Yes ☐N/A
☐ RAAM – Rapid Access to Addiction Medicine	☐ Alcohol ☐ Opiates ☐ Other:	Intake Date: _____ Completed: _____ See Notes: ☐Yes ☐N/A
☐ Seniors Mental Health 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	Intake Date: _____ Completed: _____ See Notes: ☐Yes ☐N/A
☐ WRICCP - Wellness Recovery Integrated Comprehensive Care Program	**Must meet the following criteria:** ☐ Recent suicide attempt ☐ Recent / frequent ER/Admission Inpatient ☐ Acute phase of mental health illness ☐ Significant impact to functioning	Intake Date: _____ Completed: _____ See Notes: ☐Yes ☐N/A
☐ Adult Group Therapy (check one) ☐ Depression ☐ Anxiety ☐ Bipolar ☐ Emotion Dysregulation ☐Schizophrenia ☐ ADHD ☐ Pain Control and Wellness		Intake Date: _____ Completed: _____ See Notes: ☐Yes ☐N/A
☐ Day Hospital (3 days per week)	☐ Complex mental health ☐ Impairments with daily functioning	Intake Date: _____ Completed: _____ See Notes: ☐Yes ☐N/A
☐ GEM- Guiding Emotions Mindfully (1.5 days per week)	☐ Severe emotion dysregulation ☐ History of trauma	Intake 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		Intake Date: _____ Completed: _____ See Notes: ☐Yes ☐N/A

☐ ECT – Electroconvulsive Therapy – to complete this referral you must also go to Page 4 to input additional required information	Intake 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	Intake 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	Intake Date: _____ Completed: _____ See Notes: ☐Yes ☐N/A

SECTION C: PRESENTING SYMPTOMS:

Current challenges/concerns: ☐ attached document ☐ see Meditech note dated _____

_____

_____

Previous/Current Mental Health Diagnosis (mild/moderate/severe as per PHQ-9)**:** ☐ attached document ☐ see Meditech note dated _____ _____

_____

Previous/Current Medical Diagnosis**:** ☐ attached document ☐ see Meditech note dated _____

_____

_____

Previous / Current Medication(s) / dosages**:** ☐ attached document ☐ see Meditech note dated _____

_____

_____

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): _____ M.D./N.P. Billing #: _____

Referring Source Phone: _____ Referring Source Fax: _____

Signature: _____ Referral Date: _____

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

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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 / NP?	☐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:	

Clozapine:	**CSAN Number:**
Medication Start Date:	
Follow Up Appointment for Outpatient Medication Clinic?	☐Yes ☐ No
Follow Up Appointment Made for Psychiatrist?	☐Yes ☐ No
Separate Prescription written for Clozaril (Clozapine)?	☐Yes ☐ No
Sufficient does until next appointment in Medication Clinic	☐Yes ☐ No
Deliver and fill prescription prior to Discharge?	☐Yes ☐ No
Clozaril 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 discharged on
Last CBC report
Client's history

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

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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/dehydrate, 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 ECG of bilateral / unilateral, number of treatments, response and any unusual side effects).

_____

_____

General Anesthesia History: any complications with general anesthetic? ☐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:
Anesthesia Consult: _____ Physician Consult: _____ First ECT:_____

Additional Required Information - rTMS – Repetitive Transcranial Magnetic Stimulation:

Clients <u>MUST</u> 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	☐Yes ☐ No	Please elaborate for each 'yes' indication

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:** ☐