



**Outpatient Mental Health Referral Form**

*Patient Label*

 Bar code



PLEASE COMPLETE THIS 2 PAGE FORM IN FULL BEFORE FAXING

**Intake Coordinator**

**Outpatient Mental Health Services**

**Voice Mail: (416) 469-6310 Fax: (416) 469-6116**

 Referral Date (D/M/Y) \_\_\_\_\_\_\_/ \_\_\_\_\_\_\_/ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Last Name | Given Name | Date of Birth (DD/MMYYYY) | Age | Preferred Pronoun/s |
| Address: | Apt#: | City: | Province: | Postal Code: |
| Health Card #: | Expiry Date:  |
| Gender: □ Female □ Trans-Woman □ Two-Spirit □ Gender fluid □ Androgynous □ Male □ Trans-Man □ Non-binary □ Genderqueer □ Other: |
| Primary Language Spoken: | Preferred Language: | Interpreter Required 🞏 Yes 🞏No Accessibility Concerns: 🞏 Yes 🞏No |
| Consent to leave voicemail: 🞏 Yes 🞏No  | Consent to email patient 🞏 Yes 🞏No  |
| Has internet access for Video Visits 🞏 Yes 🞏No  |
| Has this patient been seen formerly at TEHN Mental Health Service Yes No  | Phone:  | Email: |

**Which race category best describes the client you are referring:**

|  |  |
| --- | --- |
|  🞏 Black | African, Afro-Caribbean, African Canadian descent |
| 🞏 East/Southeast Asian | Chinese, Korean, Japanese, Taiwanese descent or Filipino, Vietnamese, Cambodian, Thai, Indonesian, other Southeast Asian  |
| 🞏 Indigenous (First Nations, Métis, Inuk/Inuit) | First Nations, Métis, Inuk/Inuit descent |
| 🞏 Latino | Latin American, Hispanic descent |
| 🞏 Middle Eastern | Arab, Persian, West Asian descent (eg., Afghan, Egyptian, Iranian, Lebanese, Turkish, Kurdish) |
| 🞏 South Asian | South Asian descent (eg., East Indian, Pakistani, Bangladeshi, Sri Lankan, Indo-Caribbean) |
| 🞏 White | European descent |
| 🞏 Another race category | Includes values not described above |
| 🞏 Do not know | Not applicable |
| 🞏 Prefer not to answer | Not applicable |

|  |  |  |
| --- | --- | --- |
| Referral Source: | Address: | City/Province: |
| Phone: | Fax: |  |
| Is referral being made by patient’s primary care provider? Yes No  |

Your patient should continue under your care for their Mental Health concerns until their assessment takes place. If a crisis situation arises please inform them to go to their closest Emergency Department.

**Physician OHIP #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Services Requested: (select all that apply)🞏 Psychiatric Consultation 🞏 Aftercare Clinic🞏 Time limited Counselling 🞏 Psychogeriatric clinic | 🞏 Day Treatment 🞏 Transitional Youth program |

|  |
| --- |
| **MENTAL HEALTH, ADDICTIONS CONDITIONS** |
| Please select all that apply |  Past | Present | Comments |
| Y | N | Y | N |
| Depression  |  |  |  |  |  |
| Anxiety |  |  |  |  |  |
| Mania |  |  |  |  |  |
| Psychosis |  |  |  |  |  |
| Sleeping Issues |  |  |  |  |  |
| Substance Use |  |  |  |  |  |
| Trauma |  |  |  |  |  |
| Personality Disorder |  |  |  |  |  |
| Cognitive issues |  |  |  |  |  |
| Eating Disorder Concerns |  |  |  |  |  |
| Appetite Concerns |  |  |  |  |  |
| **SAFETY AND OTHER SPECIFIC CONCERNS** |
| Suicidal Ideation |  |  |  |  |  |
| Homicidal Ideation |  |  |  |  |  |
| Suicide Attempts |  |  |  |  |  |
| Self-Harm |  |  |  |  |  |
| Violence Towards Others |  |  |  |  |  |
| Functional Impairment (ADLs / IADLs) |  |  |  |  |  |
| Sexual Concerns |  |  |  |  |  |
| Legal History |  |  |  |  |  |
| Family / Life Stressors |  |  |  |  |  |
| Family Mental Health History |  |  |  |  |  |
| Community Treatment  |  |  |  |  |  |
| Stable Housing |  |  |  |  |  |
| **MENTAL HEALTH INVOLVEMENT (select all that apply)** |
| Psychiatrist |  |  |  |  |  |
| Therapist Involvement |  |  |  |  |  |
| Other | Please specify: |
| Medications | Name: Dose: FrequencyName: Dose: Frequency Name: Dose: FrequencyName: Dose: FrequencyName: Dose: Frequency |
| Will any reports be sought other than the clinical consultation letter? Yes No  |
| Is there any matter related to compensation or insurance? Yes No  |
| Has insurance to pay for private counselling? Yes No |
| **For office use only:**Appointment Offered: \_\_\_\_\_\_/ \_\_\_\_\_/ \_\_\_\_\_\_\_\_\_\_ Clinic Assigned: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinician assigned:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Completed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/ \_\_\_\_\_/ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Name & Title) |

Please include the following documentation with the referral:

* Relevant bloodwork
* Recent vital signs
* Any relevant investigations (Eg: ECG)
* Height and weight
* Reports related to past/present mental health treatment involving the patient