



**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: Frequency  Name: Dose: Frequency  Name: Dose: Frequency  Name: Dose: Frequency  Name: 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