MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

Outpatient Mental Health Referral Form

Bar code

Patient Label

Ocean by CognisantMD — Ontario eServices Program

We now accept Ocean eReferrals for various clinics. The best way to find Specialist and refer your patients. For more information and to sign-up for your Ocean user account, contact Ontario eHealth at **eReferral@ehealthce.ca**

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
☐ Psychogeriatric clinic ☐ Women's Reproductive Mental Health Clinic

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