

Mental Health TO(MHTO) is now Help Ahead. Our service remains the same.

Outpatient Psychiatry Intake Coordinator, Help Ahead Phone: 416-438-3697 ext. 12256 Fax: (647) 480-5058

Please be informed that all referrals require the involvement of the legal guardian(s).
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.

PLEASE COMPLETE THIS 2 PAGE FORM IN FULL BEFORE FAXING

Referral Date _____ / _____ / _____

Patient Information						
Last Name		Given Name		Date of Birth (DD/MM/YYYY)	Preferred Name / Pronoun/s	
Health Card Number						
Address:			Apt#:	City:	Province:	Postal Code:
Has internet /technology access for Virtual Care YES / NO	Phone Number:		Email Address:			
	Consent to leave voicemail with patient YES / NO		Consent to email patient YES / NO			
Primary Language Spoken	Preferred Language	Interpreter Required YES / NO		Accessibility Concerns YES / NO		
Parent/Caregiver/Legal Guardian Information						
Parent/Caregiver/Legal Guardian Name:			Relationship to patient:			
Phone #			Email:			
Contact notified of the referral: YES / NO						
Consent to leave a voicemail: YES / NO	Consent to email: YES / NO		Legal guardian(s) agree to be referred to a partner hospital with a shorter waitlist if applicable: YES / NO			
Preferred Service						
<input type="checkbox"/> General Psychiatric Consultation <input type="checkbox"/> Anxiety Clinic (Assessment & Treatment) <input type="checkbox"/> Day Treatment/School Program (ages 12 -17) <input type="checkbox"/> Community Based Child and Youth Mental Health Services						

Reason for Referral / Goals for Treatment:

Patient Medical Information									
Safety and other Specific Concerns	Past	Present	Mental Health Condition	Past	Present	Mental Health Involvement	Past	Present	
Suicide Attempts			Anxiety			Community Mental Health Agency			
Self-Harm			Bipolar Disorder			Therapist/ Counsellor			
Homicidal Ideation			Psychosis			Psychiatrist			
Violence Towards Others			ADHD			Developmental Concerns	Past	Present	
Destruction of Property			PTSD			Autism Spectrum Disorder			
Fire Setting			Personality Disorder			Intellectual Disability			
Running Away			Eating Disorder			Learning Disorders			
Substance Use			Family History	Past	Present	Fetal Alcohol Spectrum Disorder			
Child Welfare Involvement			Mental Health History			Other			
Legal Charges			Family Stressors						
Custody and Access Issues			Barriers to Accessing Care						

Medications	Please describe dose, duration, adequate trial, effectiveness, adverse reactions, etc
Antidepressant medications	
ADHD medications	
Antipsychotics	
Other	
Allergies	
Medical History	

- I am aware that Help Ahead provides navigational support and may connect the patient to Michael Garron Hospital, a community child/youth mental health agency, or other suitable supports
- I am aware that psychiatric consultation does not involve ongoing treatment and that the primary care physician is expected to remain involved with this individual's mental health care
- I am aware that this psychiatric consultation is not for the purpose of forensic assessment and/or custody and access.

Referrer Information			
Site Name (Referring Doctor)	Address		City/Province
Postal Code	Phone	Fax	Referral being made by patient's primary care provider YES / NO
Billing #	Signature: _____		
Professional ID			

Instructions for this referral:

Please be aware that all referrals to Michael Garron Hospital's Child and Youth Mental Health Outpatient Programs are now being processed by Help Ahead.

Help Ahead is a single access point for infants, children, youth up to 18 and their families in Toronto to find and get the mental health help they need efficiently and quickly. Once we connect your patient to services, Help Ahead will provide you with an update on the disposition.

Please include the following documentation with the referral:

- Relevant Bloodwork
- Height and Weight
- Recent vital signs
- Any relevant investigations (Eg: ECG)
- Reports related to past / present mental health treatment involving patient or family

For urgent but non-emergent concerns, please contact Help Ahead directly at 1-866-585-6486

Please consider signing up for Ocean e-referral, to submit patient referrals directly from your electronic health record, with access to up-to-date specialist and program directories. More information can be found at:

<https://www.cognisantmd.com/ocean-ereferrals/>