



ADULT MENTAL HEALTH SERVICES REFERRAL

PHONE: (519)637-0511 Fax: (519)631-6497

Date of Referral: _____ MRN# _____

Please note: Our service is not able to provide immediate support in an emergency.

If your patient is experiencing a mental health crisis and requires immediate help – advise them to contact REACH OUT (24 hour crisis line) 1-866-933-2023; or go to their nearest emergency department.

We are unable to provide Independent Medical Evaluations for Court, CAS Assessments; ODSP, WSIB, Forensics or Capacity Assessments.

Patient Information

Last Name: _____ First Name: _____ Age: ____ (*18 years+)

DOB:(YYYY/MM/DD): _____ OHIP # _____ VC: _____

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____ Voice Mail OK? Yes

No emailing or texting is available.

If patient has a family doctor or psychiatrist, please consult treating physician prior to referral.

Family Physician: _____ **Psychiatrist:** _____

Current Safety Risk Factors (Assess and check all that apply and provide details below)

- Active suicidal thoughts Passive suicidal thoughts History of suicide attempt
- Current intentional self-harm behaviours Current substance abuse
- History of violence/aggression Thoughts to harm others
- Behaviour influenced by delusions/command hallucinations

Reason for Referral and Goals for Treatment (Attach relevant notes/assessments, if available)

Blank space for Reason for Referral and Goals for Treatment.

Physical Health (Note any relevant medical history)

Blank space for Physical Health.

All Current Medications (List dose, frequency and date started)

- Current Medication List or Cumulative Patient Profile Attached

Prior Psychiatric Medications: _____

Current Supports and Resources

Blank space for Current Supports and Resources.

Referral Source

Name: _____ Phone #: _____ Fax#: _____

Address: _____ City: _____ Postal Code: _____

- Family Physician Nurse Practitioner ED Physician Walk-In-Clinic Physician

Signature: _____