

**Our service is not able to provide immediate support in an emergency; however, we are able to see patients within 1-2 weeks. If your client is experiencing a mental health crisis and requires immediate help – advise them to contact REACH OUT (24-hour crisis line): 519-433-2023; or go to their nearest emergency department, or the Canadian Mental Health Association’s Crisis Centre located at 648 Huron St. in London.**

**If your client requires a non-urgent referral, please see the Adult (18-64) Ambulatory Mental Health and Addictions Referral Form.**

Our program provides an interprofessional, collaborative service between London Health Sciences Centre (LHSC) and St. Joseph’s Health Care (SJHC) London. Our goal is to provide an urgent, consultative care model for clients with limited follow-up and to coordinate access to available resources within LHSC and the community, as appropriate.

If you are a specialist submitting this form, Primary Care Physician has been informed of this referral

Patient does not have a family physician

**Inclusion Criteria**

- Individuals ages 18 to 64 (Early Intervention/First Episode Programs provide treatment to youth aged 16 and older)
- Serving residents of London and Middlesex County
- Patient has a primary care provider or has seen a physician at a walk-in clinic who is agreeable to follow up on recommendations provided

**Was this referral discussed with the client?**  Yes  No

**Is the client willing to accept services?**  Yes  No

**Exclusion Criteria**

- Court/legal/insurance purposes: Competency Assessment, Forensic Assessments, or involvement to satisfy third-party requests

**Client Information**

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Preferred Pronoun: \_\_\_\_\_

OHIP #: \_\_\_\_\_ VC: \_\_\_\_\_

Current Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Is interpretation required?  Yes  No

If yes, what language: \_\_\_\_\_

Personal Phone #: \_\_\_\_\_

Alternate Phone #: \_\_\_\_\_

Does client have a Substitute Decision Maker?  Yes  No

SDM name and contact info: \_\_\_\_\_

Does client have a community treatment order?  Yes  No

**Reason for Referral and Goals for Treatment**

**Reason/Goals for Referral (Required):** \_\_\_\_\_

Medication List (Required): \_\_\_\_\_

Client Name: \_\_\_\_\_

**Previous Mental Health Treatment / Hospitalizations**

(Attach psychiatric and diagnostic history, including consult/progress notes, admission notes, discharge summaries, etc.)

 It is mandatory to send the list of all current and previous medication trials otherwise referral will be returned See attachments  See Clinical Connect**Current Safety Risk Factors (Assess and check all that apply)**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Active suicidal thoughts                                 | <input type="checkbox"/> Passive suicidal thoughts           | <input type="checkbox"/> History of suicide attempt(s)            |
| <input type="checkbox"/> Thought to harm others                                   | <input type="checkbox"/> History of violence/aggression      | <input type="checkbox"/> Current intentional self-harm behaviours |
| <input type="checkbox"/> Behaviour influenced by delusions/command hallucinations | <input type="checkbox"/> Other, <b>please</b> specify: _____ |   |

**Presenting Symptoms \*Check all that apply and provide details below**

Primary diagnosis, if known: \_\_\_\_\_

- |   |  |  |  |   |
|---|--|--|--|---|
| <input type="checkbox"/> Depressed Mood     | <input type="checkbox"/> Mania/Hypomania                     | <input type="checkbox"/> Anxiety/Panic                           | <input type="checkbox"/> Post-traumatic stress | <input type="checkbox"/> Psychosomatic Symptoms |
| <input type="checkbox"/> Gender Dysphoria   | <input type="checkbox"/> Disruptive/Impulse Control Concerns | <input type="checkbox"/> Personality Disorder Symptoms           | <input type="checkbox"/> OCD                   | <input type="checkbox"/> ADHD                   |
| <input type="checkbox"/> Psychotic Symptoms | <input type="checkbox"/> Eating Disorder                     | <input type="checkbox"/> Current substance abuse, specify: _____ |  |   |

 Please Provide Details: \_\_\_\_\_**Referring Source Information**

Referring Physician: \_\_\_\_\_ Billing #: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Office Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

If you have any inquiries or require clarification regarding this referral form, please contact the Centralized Access Point (CAP), Ambulatory Mental Health and Addictions Program at LHSC (519-685-8500 ext. 76777) during business hours (Monday through Friday from 8:30 a.m. – 4:30 p.m., excluding holidays).

**To submit this referral send the completed referral form and relevant attachments to the Centralized Access Point Office at LHSC  
FAX: 519-667-6685**