

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 needs to be seen within 1-2 weeks, please see the Adult (18-64) Urgent Consultation Service (UCS) 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 a non-urgent, time-limited, consultative care model for clients and to coordinate access to available resources within LHSC and the community.

- 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 primary care provider or has seen a physician at a walk-in clinic who is agreeable to follow up on recommendations provided

Exclusion Criteria

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

Was this referral discussed with the client? Yes No

Is the client willing to accept services? Yes No

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 #: _____

Vmail?

Alternate Phone #: _____

Vmail?

Email: _____

I am a healthcare provider submitting patient information on behalf of a patient. I acknowledge I have obtained informed consent from the patient whose information will be used to make this referral to accept all risks associated with electronic communication including: email and other electronic forms of communication are not secure or confidential forms of communications; unencrypted messages that are sent across the internet could potentially be intercepted and read by unintended parties; and while London Health Sciences Centre and St Joseph's Health Care use anti-virus software to protect all devices, viruses and malware may be unintentionally transmitted.

Does client have a Substitute Decision Maker? Yes No

SDM name and contact info:

Does client have a community treatment order? Yes No

Please select one of the two following options based on goals for referral:

Psychopharmacology Consultation only

- Primary Care Physician (PCP) must have initiated medication treatment that has not been effective
- Patient is seeking **medication-based treatment only**
- In most cases, patient will be seen for a one-time consultation, followed by treatment recommendations to be implemented by patient's PCP

Please use [eConsult](#) as the preferred initial route of management. If patient still requires in person assessment, you may complete this form.

Comprehensive Interdisciplinary Mental Health Assessment

- Patient will first be seen by a clinician for a complete psychosocial assessment, followed by an interdisciplinary team review and assessment by a psychiatrist, if necessary.
- **Short-term** (up to 6 months) follow-up may be offered as required
- Patient's PCP is required to remain active during this process & patient will be discharged back to their PCP with a treatment plan

Client Name: _____

OPTIONAL: Request for Specialized Program Instead of Above General Program Options

(Please ensure information <90 days old)

Adult Eating Disorders Service

Ht(cm): _____ Wt(kg): _____

Temp: _____

Lay: BP _____ HR _____

Stand: BP _____ HR _____

Frequency per week:

Exercise _____

Binging _____

Laxative Use _____

Vomiting _____

Patient Condition:

Type 1 diabetes Pregnant

Mandatory Attachments:

Blood work ECG

PEPP – Prevention and Early Intervention Program for Psychosis

Suspected first episode of psychosis and no significant antipsychotic treatments provided yet

Clients aged 16 – 35 years

No methamphetamine use in the last three (3) months

FEMAP – First Episode Mood Anxiety Program

Mood or anxiety complaint in the absence of prior long-term (viz., 18 months) treatment

Clients aged 16 – 25 years

Less than 18 months lifetime psychiatric medication use (excepting psychostimulants)

No developmental delay or substantial learning disability (i.e. needed an IEP due to learning problems in school)

No traumatic brain injury

CDP – Concurrent Disorders Program

The address is in London-Middlesex Y N

Has a suspect or confirmed substance use disorder, gambling disorder, or other addiction Y N

Has a suspect or confirmed major mental illness Y N

Has an existing psychiatrist or care team Y N

Is supported by a community addictions services Y N

Presenting Symptoms *Check all that apply and provide details below

Primary diagnosis, if known: _____

Depressed Mood Mania/Hypomania Anxiety/Panic Post-traumatic stress Psychosomatic Symptoms

Gender Dysphoria Disruptive/Impulse Control Concerns Personality Disorder Symptoms OCD ADHD

Psychotic Symptoms Eating Disorder History of violence/aggression

Current substance abuse, specify: _____

Please Provide Details: _____

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

- Active suicidal thoughts Passive suicidal thoughts History of suicide attempt(s)
 Thought to harm others History of violence/aggression Current intentional self-harm behaviours
 Behaviour influenced by delusions/command hallucinations Other, **please** specify:

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

Relevant Medical / Developmental History (i.e. developmental delay, epilepsy, dementia, acquired brain injury, etc.)

Psychosocial / Other Issues

- Marital/custody Sexual abuse Emotional abuse Financial issues Housing
 Work/school problems Anger/temper Grief/traumatic loss Charges pending On trial/incarcerated

Was this referral discussed with the client? Yes No **Is the client willing to accept services?** Yes No

Client Name: _____

Referring Source Information

Name: _____ Billing #: _____
 Phone #: _____ Fax #: _____
 Office Address: _____
 City: _____ Postal Code: _____

- Family Physician/NP Walk-In Clinic
 Other: _____
 Does the client have a current Psychiatrist? Yes No
 Psychiatrist Name: _____

REFERRING SOURCE 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**