DAY TREATMENT PROGRAM REFERRAL

ADULT MENTAL HEALTH

1235 Wilson Ave., 5th Floor (East Outpatient Elevators), Toronto, Ontario M3M 0B2
Phone: 416-242-1000 ext.43170 Fax: 416-242-1024

PATIENT INFORMATION **Date:** ____/____/____ (d/m/y)

PATIENT NAME (print):________________________/____________________ **Sex:** F M D**OB:** ____/____/____
last name first name (d/m/y)

ADDRESS: ____
Street City Postal Code

PREFERRED PHONE: ______________________ Can a message be left? **Y N** With another person? **Y N**

OHIP #:__________________________________ **Version Code:** ________**If IFH, attach copy of certificate:** ☐

Can the patient communicate in English? If not, please specify: ____

REFERRING PHYSICIAN

Name (print): ____ **Billing #:**______________________________

M.D. Phone: __________________________________ **M.D. Fax:**____________________________________

Mailing Address (*for copies of consults to be sent*):____

____

REFERRAL INFORMATION ***Please attach any relevant information, such as discharge summaries, previous assessments, psychologist reports, recent lab work, etc.***

Diagnosis: ____

Reason for referral/Goals for Treatment (specify):____

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____

History (include past treatments):____

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____

ACTIVE MEDICAL CONDITIONS____

____

____

MEDICATIONS____

____

Criminal/Legal Issues Pending? ☐ Yes ____ ☐ No
Gambling Problems? ☐ Yes ____ ☐ No
History of Self-Harm/Suicide Attempts? ☐ Yes ____ ☐ No
Aggressive Towards Others? ☐ Yes ____ ☐ No
Intellectual Disability? ☐ Yes ____ ☐ No

Rev: 24-Oct-17