HUMBER RIVER HOSPITAL

ADULT MENTAL HEALTH & ADDICTIONS OUTPATIENT CLINIC REFERRAL

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

****PLEASE NOTE:** *We do not provide reports or diagnostic assessments solely for disability applications/appeals, CAS, child custody parenting capacity, divorce or insurance claims. Lawyers who require a report for their clients for legal charges, may be referred to CAMH Law & Mental Health Program at 416-535-8501 ext. 2945.*

PATIENT INFORMATION

Date: ____/____/____ (d/m/y)

PATIENT NAME (print):_____/_____ **Sex:** F M DOB: ____/____/____
last name first name (d/m/y)

ADDRESS: _____
Street City Postal Code

PREFERRED PHONE: _____ Can a message be left? Voice mail? **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):* _____

_____

We require the referring MD to continue to be available for ongoing medical care
I WILL CONTINUE TO PROVIDE MEDICAL CARE AND FOLLOW UP TO THIS PATIENT: ☐ **(required)**

REFERRAL INFORMATION

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

☐ Depression ☐ Anxiety ☐ Psychosis ☐ Drug/Alcohol Addictions ☐ Other _____

I CAN PARTICIPATE IN SHARED MENTAL HEALTH CARE FOR THIS PATIENT (*see letter) ☐ **Y** ☐ **N**

Reason for requesting this referral *(specify):* _____

_____

_____

History (include past treatments): _____

_____

_____

_____

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

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