

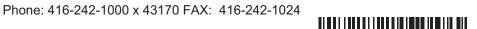
MENTAL HEALTH & ADDICTIONS OUTPATIENT CLINIC REFERRAL

FAX TO: 416-242-1024 INQUIRIES: 416-242-1000 ext. 43170 WEBSITE: www.hrh.ca

Our Model of Care has changed for Adult Mood & Anxiety referrals. Please ensure you have reviewed these changes with your patient prior to referring (see instruction page).

☐ Please confirm that the referrer/Primary Care Provider will continue to provide medical care to this patient.				
Patient Information:		·	· · · · · · · · · · · · · · · · · · ·	
Last Name:	First Name:			
Preferred Name:	Health Card#:		Version Code:	
Gender:	Pronouns:	Birthdate:	Age:	
Address:				
City:	Province:	Postal Code:		
Considerations: ☐ Cognitive Impairment ☐ Hearing Impairment ☐ Sight Impairment ☐ Age 65 + Housebound ☐ Mobility Issues ☐ Language Barrier (specify language needed for translation) ☐ other:				
Contact Information: By listing phone numbers/email addresses below, the referral source confirms that the client consents for HRH to call/email them or their alternate contact regarding this referral and appointment booking.				
Phone:		Consent t	o leave message: ☐ yes ☐ no	
Email :				
Alternate contact				
Name:	Phone #:			
Relationship:				
Referral Source Information	on:			
Name:		□ MD □ NP	Billing #:	
Address:				
Signature:		Phone #:		
Referral Date:		FAX # :		
Primary Care Provider Nan	<mark>ne:</mark>	Phone #:		
Medical History: Please attach relevant clinical and medical				
Custody Status (for youth under age of 16) PLEASE FILL OUT CONTACT INFORMATION FOR GUARDIAN(S) Considerations: □ Joint Custody (please fill in contact information for both guardians) □ Sole Custody □ Live with both parents/married/common law □ Other:				
Guardian Name: Guardian Name:		Phone #: Phone #:		

Form # 000849, version (08-2021)





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Patient Name: Last name: First Name:

Reason for Referral: Chief psychiatric complaint/clinical question: Symptoms, stressors, and changes to functioning. Include scores from scales if relevant (eg., PHQ-9):	Services Requested: Please check all that apply □ Diagnostic Clarification □ Medication Recommendations □ Mood & Anxiety (Stepped Care Program) □ Early Intervention in Psychosis Program □ Psychosis Day Program □ Addictions Treatment & Recovery Support □ Adult MD to MD Consult □ Child & Adolescent Consultation <18 □ Child & Adolescent Transition Day Program <18			
Risk & Safety – Please include ALL past and current behaviours ☐ Violence ☐ Agitation ☐ Self Harm ☐ Suicide attempt ☐ Suicidality Details:				
Has patient been assessed by a psychiatrist in the past? □ yes □ no (If yes please attach consultation)				
Current & Past History – Please check all that apply and attach relevant notes/consults Anxiety				
Mental Health & Addictions Treatment – Past and Present (therapies, hospitalizations & community agency involvement)				
Medication History (Please list all current medications and ALL property) Medication Name Current Dose Frequency □ yes □ no □ yes □ no □ yes □ no □ yes □ no □ yes □ no □ yes □ no □ yes □ no □ yes □ no □ yes □ no □ yes □ no □ yes □ no	nast psychiatric medications – attach list if necessary) Response & Adverse Effects			