Humber River Hospital

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 to leave message:** ☐ yes ☐ no

Email :

Alternate contact

Name: Phone #:

Relationship:

Referral Source Information:

Name: ☐ MD ☐ NP Billing #:

Address:

Signature: Phone #:

Referral Date: FAX # :

Primary Care Provider Name: 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:

1. Guardian Name: Phone #:
2. Guardian Name: Phone #:

Humber River Hospital, **Mental Health & Addictions**, 1235 Wilson Avenue, 5th Floor, Toronto, ON M3M 0B2
Phone: 416-242-1000 x 43170 FAX: 416-242-1024

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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

	Past	Current		Past	Current		Past	Current
Anxiety	☐	☐	Trauma Symptoms / PTSD	☐	☐	Substance Use Concerns	☐	☐
Bipolar Disorder	☐	☐	Psychosis	☐	☐	Cognitive Decline/Confusion	☐	☐
Depression	☐	☐	ADHD/Learning Disability	☐	☐	Obsessive Compulsive Disorder	☐	☐

DETAILS:

Mental Health & Addictions Treatment – Past and Present *(therapies, hospitalizations & community agency involvement)*

Medication History *(Please list all current medications and ALL past psychiatric medications – attach list if necessary)*

Medication Name	Current	Dose	Frequency	Response & Adverse Effects
	☐ yes ☐ no			
	☐ yes ☐ no			
	☐ yes ☐ no			
	☐ yes ☐ no			
	☐ yes ☐ no			
	☐ yes ☐ no			
	☐ yes ☐ no			