Humber River Hospital

PLEASE READ CAREFULLY BEFORE COMPLETING/SUBMITTING REFERRAL FORM

MENTAL HEALTH & ADDICTIONS OUTPATIENT CLINIC REFERRAL

Instructions and Information

Please review the following information with your patient:

We have transitioned to a Stepped Care Model for Adult Mood & Anxiety referrals. Services will be offered based on appropriateness, availability, and patient preference, and may include psychiatric consultation and brief treatment, where appropriate. Please note: Not all patients will be seen by a psychiatrist, and emphasis will be on providing episodes of care. Once treatment is completed the patient will be discharged back to the referring source.

The Mental Health & Addictions Clinic does not offer psychiatric assessments for legal, insurance, custody, CAS, WSIB or forensic reasons.

This form is not for individuals experiencing crisis or in need of urgent care.
Patients experiencing a mental health or addiction emergency
should be directed to the nearest emergency department.

Referral Process:

Please ensure your patient is aware of this referral. Intake staff will make **two** attempts to reach the patient and leave two voice mail messages. The number will appear as Humber River Hospital. If we are unable to reach the patient, the referral source will be notified by fax and the referral form will be inactivated.

All referrals are reviewed by an Intake Clinician. The referral will be forwarded directly to the appropriate service, or a telephone screening will be scheduled with the patient to gather more information and determine the next step. Patients are welcome to contact us directly at 416-242-1000 ext. 43170 to discuss their referral at any time.

How to submit a referral:

- Review the above information with your patient to ensure expectations are aligned
- Fax the completed form to 416-242-1024
- Fax each referral form individually
- To help us provide the best care for your patient, please include all relevant documents including previous psychiatric consultations or discharge summaries, psychological reports, medication sheets, medical reports, lab and test results

Form # 000851, version (08-2021)

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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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 #:

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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			