Mental Health Ambulatory Services Referral Form

Phone: 705-728-9090 Psychiatry: x47210 MHA Day Program X47260
Fax: 705-739-5631

Royal Victoria Regional Health Centre

The Mental Health Ambulatory Services accepts referrals where there is a primary psychiatric concern. We provide short term consultation and stabilization for patients age 16 and above.

Referral forms that are incomplete will not be processed and will be returned. The Mental Health Ambulatory Services accepts referrals for patients living within the primary catchment of the Greater Barrie area.

Client/Patient Information

Date patient was last seen: _____ Sex: ☐ Male ☐ Female
(yyyy/mm/dd)

Is patient agreeable to referral? ☐ Yes ☐ No **If no, please do not proceed with referral**

_____ _____
Patient Name Date of Birth (yyyy/mm/dd)

_____
Address

_____
Health card number

_____ Can leave message? ☐ Yes ☐No
Provide a working phone number

Marital status ☐ Single ☐ Divorced ☐ Separated
(this information is used by the hospital to register patients) ☐ Married ☐ Widowed

All referrals will be screened for appropriateness.

We are NOT able to accept referrals for assessments/treatment where concerns are related primarily to:

Anger management
Autism spectrum disorders
Chronic pain
Developmental delay
Relationship counselling

We do not provide assessments for legal, insurance, custody, Children's Aid Society (CAS), Workplace Safety and Insurance Board (WSIB) or forensic reasons

Is the patient involved in current/pending legal, compensation or insurance claims? ☐ Yes ☐ No

If yes, please explain: _____

Service Request:

Psychiatric Consult (select one):		**Mental Health & Addiction Day Program** (select one):
☐ Medication review	☐ Diagnostic clarification	☐ Mental Health & Addiction Day Program
☐ Short-term management	☐ Ontario Telemedicine Network (OTN) if available	☐ Brief transitional case management

Reason for referral:

_____

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Current Medications	Past Medications Please list side effects if any/reason for discontinuation

How medications are funded:
☐ Ontario Disability Support Program/Ontario Works ☐ Private Insurance ☐ Self-Pay

Medical Condition(s)

☐ No known allergies Allergies:_____

Psychiatric Symptoms

☐ Fluctuating mood (mood swings)
☐ Obsessive compulsive symptoms
☐ Phobia(s):_____
☐ Other anxiety symptoms
☐ Attention deficit/hyperactivity
☐ Elevated mood
☐ Depressed mood
☐ Sleep disturbance
☐ Delusions
☐ Hallucinations
☐ Memory impairment
☐ Personality traits
☐ Substance use
☐ Confusion
☐ Abnormal eating behaviours
☐ Panic symptoms or attacks

Psychosocial Issues

☐ Marital/Common-law/Partner problem
☐ Lack of social supports/isolated
☐ Physical/sexual abuse in childhood
☐ Current physical/sexual abuse
☐ Sexual problem
☐ Past substance use
☐ Current substance use
☐ Separation/divorce
☐ Anger/temper control
☐ Bereavement
☐ Financial Issues
☐ Housing
☐ Parenting issues
☐ Work problems
☐ Self Esteem
☐ No employment

Addictions:

Does the patient use illegal drugs or misuse prescription drugs?	☐ Yes	☐ No
Does the patient drink alcohol?	☐ Yes	☐ No
Has either caused the patient problems in their life recently?	☐ Yes	☐ No
Does the patient want to learn more about drug & alcohol treatment?	☐ Yes	☐ No

Referring Source Information (Referrals accepted from physician or nurse practitioner)

Referred by: ☐ Family Physician
☐ Psychiatrist
☐ Nurse Practitioner

_____
Referring clinician's name

_____
Billing No.

_____
Telephone Fax

Stamp/label here if applicable

Mental Health and Addictions Program Use Only

Date referral received:	Date decision made or call:	Date access for service:
_____	_____	_____