St. Michael's

Inspired Care.
Inspiring Science.

COMMUNITY MENTAL HEALTH PROGRAM
Referral Form

If the individual requires an urgent assessment, please utilize existing emergency services.

CATCHMENT AREA: **ONLY REFER PATIENTS LIVING IN THIS CATCHMENT AREA**
South of Bloor/Danforth to Lakeshore Ave
East of Yonge St to Victoria Park Avenue

*******Please ensure that ALL RELEVANT PSYCHIATRIC ADMISSION HISTORY AND DOCUMENTATION ARE ATTACHED to the completed referral form or PROCESSING MAY BE DELAYED. *******

Fax completed form to Intake at (416) 864-3091

For further information, call the Central Intake Service at (416) 864-5120.

SECTION A: PATIENT INFORMATION

Client Name: _____ **Sex:** _____ **Date of Birth:** _____

Client Address: _____

Telephone Number: Home _____ **Work** _____

Emergency Contact: _____

Health Card Number and Version Code: _____**St. Michael's J#:**_____

Name of Family Doctor:_____ **Phone number:** _____

SECTION B: REFERRAL SOURCE INFORMATION

Name of Person Making Referral: _____

Name of Referring Organization/Agency: _____

Referral Source Address:_____

Telephone #: _____ **Fax #:** _____

Referral Date: _____ **MD OHIP Registration #** _____

SECTION C: PLEASE PROVIDE AS MUCH INFORMATION AS POSSIBLE

1. **Reason(s) for requesting this consultation:** What **specific question(s)** do you want answered? What is your **goal for this assessment?**

_____

_____

_____

_____

2. **Diagnosis (if known):**

   Primary: _____

   Secondary: _____

3. Current psychiatric presentation (please be specific regarding signs/symptoms):

_____

_____

_____

_____

4. Past and present psychiatric diagnoses and treatments: Specify all medications tried, with doses. Specify all current therapies. Attach relevant reports.

_____

_____

_____

_____

5. Service Use: List all known **psychiatric hospitalizations in the last five years**:

*****Be sure to attach any discharge summaries, final notes, or progress notes.*****

Hospital	Admission & Discharge Dates	Reason(s) for Admission

List all known crisis or emergency contacts over the past year:

Location	Date	Reason(s) for seeking crisis/emergency intervention

6. Please list any individuals or agencies that are currently providing community support/case management to the client. Please identify the individual's primary worker with an asterisk (*).

Name of Individual/Agency	Contact Person	Telephone Number	Services Provided

7. Please indicate whether the individual/agency that is currently providing primary support to the client is aware of and in agreement with this referral if applicable:

Yes No

8. Relevant medical history: Specify developmental, medical and neurological conditions or complications. Include other medications if applicable.

_____

_____

_____

_____

9. Please indicate on the following chart if any of the following are applicable to this referral.

Is there a history of any of the following?	Yes	No	Unsure	Please Specify:
Developmental Handicap				
Head injury				
Cognitive disorder				
Personality disorder				
HIV				
Homelessness				
Substance use				
Violent behaviour				
Suicide attempts				
Other self-harm behaviour				
Legal involvement				
Care history (CAS,CCAS)				
Learning disorders				

10. Please complete each row of the following chart.

	Yes	No
Is this a request for a second opinion? **If so, why?**		
Is the client's current primary care provider aware of this referral? **Please attach an assessment report or letter from the client's primary care provider prior to sending the referral**		
Is the client aware that he/she will be seen for a consultation? **Please note that follow up services are not guaranteed**		
Will any reports be sought other than the clinical consultation letter? **Please note that we may not be able to complete forms during a consultation**		
Is there any matter related to compensation or insurance? **If so, please describe**		

Please specify details regarding the above:

_____

_____

_____

SECTION D: ADDITIONAL COMMENTS

Use this space if you wish to make additional comments.

_____

_____

_____

_____

Community Mental Health Service
St. Michael's Hospital
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416-864-5120