SHN-CENTRALIZED INTAKE MENTAL HEALTH OUTPATIENT PROGRAMS REFERRAL FORM

Phone: 416-431-8135 (press 2) Fax: 647-251-4740

SHN
SCARBOROUGH HEALTH NETWORK

DATE: _____

SHN's Outpatient Mental Health Program accepts referrals where there is a primary psychiatric concern. We provide short-term consultation and stabilization. Please note that referrals are processed within 72 hours and all referrals are triaged. Referrals found to be urgent by our clinical assessment team will be prioritized for patient contact and we aim to have an appointment with a psychiatrist or clinical staff made within 4 weeks. **If you are concerned that a patient is actively suicidal/homicidal, please direct them to the nearest hospital Emergency Department.** IMPORTANT: Please included supporting documentation, where appropriate. Typed forms are Preferred. **Incomplete or illegible referrals will delay service.**

Client consented to: ☐ Referral ☐ Communication by email ☐ Voicemail message(s) being left

SDM/POA: ☐ Documentation provided

Patient History at SHN Mental Health: ☐ New Request ☐ Re-referral (Reason): _____

DEMOGRAPHIC INFORMATION

Patient Name (Last, First):			**Preferred Name:**
DOB (yyyy/mm/dd):	**Age:**	**Gender**	**Pronouns:**
Address:	**Postal Code:**	**City:**	
Health coverage OHIP#/IFH#/ Other (specify):			**Version Code:**
Primary Phone number:		**Secondary phone #:**	
Email:			

PRESENTING CONCERNS

Referral Goal: Psychiatry: □ Diagnostic Clarification □ Medication Review
Therapy Programs: □ (Please attached recent PHQ and GAD)

Has your patient ever been assessed by a psychiatrist? □ No □ Yes – provide **consult notes/ discharge summary**

Factors contributing to current referral:

□ Suicidal/Self-Harm □ Recent Violent Behaviour/Risk □ Pregnant □ Postpartum <1year
□ Recent ED Visit/Discharge □ Legal Involvement □ CTO □ Clozaril/Depot

□ Substance Use (specify):

Describe presenting problems, current symptoms. If urgent, please explain further:

How long has this been a concern? □ Less than 1 month □ Up to 1 year □ More than one year

Is the patient currently receiving treatment for this concern? □ No □ Yes

If yes - Provider name, discipline, type of treatment:

MEDICATIONS

****Attach list of all medical and psychiatric medications and diagnostics**

Current Medication(s)	Past Medications (side effects if any, reason for discontinuation)

MEDICAL CONDITIONS

☐ No known allergies ☐ Allergies (specify):

PHYSICIAN/NP INFORMATION

STAMP

Referring Physician/NP:	**Phone #:**
Billing #:	**Fax #:**