CENTRALIZED INTAKE MENTAL HEALTH OUTPATIENT PROGRAMS REFERRAL FORM

Phone: 416-284-8131 ext. 4222 Fax: 416-281-7320

SHN
SCARBOROUGH HEALTH NETWORK

SHN's Outpatient Mental Health Program accepts referrals where there is a primary psychiatric concern. We provide short-term consultation and stabilization. Upon receipt of your completed referral, our central intake team will review and determine how to best serve your patient. If our central intake team determines that your patient requires urgent intervention, our goal is to see them within 14 days. Reports and documentation will be completed as required only in the context of treatment. **If you are concerned that a patient is actively suicidal/homicidal, please direct them to the nearest hospital Emergency Department.**

DATE: _____

DEMOGRAPHIC INFORMATION

Patient Name (Last, First):			**Preferred Name:**
DOB (yyyy/mm/dd):	**Gender:**	**OHIP #:**	**VC:**
Address:			**City:**
Postal Code:	**Primary Phone #:**		**Secondary Phone #:**
Email:			

PRESENTING CONCERNS

Referral Goal: ☐ Diagnostic Clarification ☐ Medication Review ☐ Second Opinion ☐ Internal Referrals: _____

Patient History at SHN Mental Health: ☐ New Request ☐ Re-referral

Describe presenting problems, current symptoms, and reason for urgency:

How long has this been a concern? ☐ Less than 1 month ☐ 1 to 6 months ☐ More than 6 months

Currently receiving treatment for this concern? ☐ No ☐ Yes
If yes - Provider name, discipline, type of treatment:

Has your patient ever been assessed by a psychiatrist? ☐ No ☐ Yes
If yes – please provide psychiatric **consult notes** and/or **discharge summary** indicating treatment termination

MEDICATIONS

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

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

MEDICAL CONDITION

☐ No Known Allergies ☐ Allergies (specify):

FACTORS CONTRIBUTING TO CURRENT REFERRAL

☐ Suicidal ☐ Recent Violent Behaviour/Risk ☐ Pregnant ☐ Postpartum <1year
☐ Recent ED Visit/Discharge ☐ Legal Involvement ☐ CTO ☐ Clozaril/Depot
☐ Substance Use (specify):

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

PHYSICIAN INFORMATION

Referring Physician:
Telephone #:
Billing #:
Fax #:

STAMP

FAX TO: 416-281-7320 **Incomplete or illegible referrals will delay service.**