SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9

Mental Health Program – TEL. (905) 895-4521, ext. 2666
FAX: (905) 830-5987

Health Record #: _____ Complete or place barcoded patient label here
Patient Name: *(Print first, last)* _____
DOB: mm / dd / yy Age: _____ ❑ Female ❑ Male
OHIP #: _____ Version Code: _____
Account #: _____ Date of Admission: mm / dd / yy

Adult Out-patient Referral/Psychiatric Consult Request

Date of Referral: mm / dd / yy

Please print clearly and include any relevant medical reports, medication sheet, psychological reports, and copies of previous psychiatric consultations or discharge summaries. For specific program information and criteria please refer to Southlake Regional Health Centre Mental Health website, www. southlakeregional.org. **INCOMPLETE REFERRALS WILL NOT BE PROCESSED.**

Choose service this referral is indicated for:

❑ ECT *Specify:* _____
❑ Brief Therapy Clinic: ❍ Individual ❍ Group ❍ Couple
❑ Adult Crisis Program (Urgent Clinic) ❑ Psychiatric Consult
❑ Day Program: ❍ Wellness ❍ Recovery
❑ Schizophrenia Clinic ❑ Discharge Clinic

CLIENT/PATIENT INFORMATION

Name: *(print first, last)* **Date of Birth:** mm / dd / yy

Address: Street Number + Name Apartment City Province Postal Code

Contact Number: ❑ OK to call – **OK to leave message:** ❑ on voicemail ❑ with person

Alternate Number: ❑ OK to call – **OK to leave message:** ❑ on voicemail ❑ with person

Sex: ❑ Male ❑ Female **Health Card Number:** **Version Code:**

Name of Emergency Contact: *(print first, last)*

Relationship to Patient:

Contact Number: ❑ OK to call – **OK to leave message:** ❑ on voicemail ❑ with person

Alternate Number: ❑ OK to call – **OK to leave message:** ❑ on voicemail ❑ with person

RISK ISSUES

ANY HISTORY AS FOLLOWS?	YES	NO	IF YES, WHEN?	COMMENTS
Criminal Charges	❑	❑		
Violent Behaviour	❑	❑		
Suicidal Attempts	❑	❑		
Other Self Harm Behaviour	❑	❑		

CURRENT MEDICATIONS *(Psychiatric and Non-Psychiatric)* ***Please attach/or fax Southlake physician order sheet and/or prescription***

MEDICATION	DOSE/FREQUENCY/ROUTE	SCRIPT ATTACHED	COMMENTS
		❑	
		❑	
		❑	

For Injectable Medication: **Date Last Given:** mm / dd / yy **Next Date Due:** mm / dd / yy

How the medications are funded: ❑ ODSP ❑ ODB ❑ Private Insurance ❑ Self-Pay

❑ Drug Card Number: _____ *(attach copy or contact information for client's pharmacy)*

SL0504_14 (09/17) "Adult Outpatient Mental Health" Review (09/20)

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CURRENT AND PAST PSYCHOTHERAPIES OR OTHER THERAPIES

THERAPY	WHEN/DURATION	OUTCOME

Allergies: _____

Relevant Medical History – *Typed consult or history notes attached:* ❑ No ❑ Yes

_____

Diagnosis and Psychiatric Presentation: _____

_____

Is there any legal or forensic aspect to this referral? ❑ No ❑ Yes *(specify)* _____

_____

Is this client/patient involved in current/pending compensation/insurance claims? ❑ No ❑ Yes

WE DO NOT ACCEPT REFERRALS PRIMARILY DEALING WITH COMPENSATION/INSURANCE ISSUES OR COURT ORDERED TREATMENT.

REFERRING SOURCE INFORMATION

Referred by: *(Check ✔ one)* ❑ Family Doctor ❑ Psychiatrist ❑ Southlake Program ❑ Other *(specify)* _____

Reason For Referral: _____

_____

_____

Referring Name: *(print first, last)*		**Signature:**
Phone Number:	**Fax Number:**	**Email:**
Name of Family Doctor: *(print first, last)*		**Phone Number:**

THIS SECTION ONLY TO BE COMPLETED BY SOUTHLAKE OUT-PATIENT PROGRAM STAFF

Date Received: mm / dd / yy **Contacted:** ❑ No ❑ Yes

Intake Date: mm / dd / yy **Referral Declined:** ❑ By client ❑ By program

Comment:

Staff Name: *(print first, last)*	**Designation:**
Staff Signature:	**Date:** mm / dd / yy **Time:** _____

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