SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9

Mental Health Program

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 Outpatient Referral – FAX TO: 905-830-5987 TEL. (905) 895-4521, ext. 2666

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.***

Note: Choose service this referral is indicated for: **Date of Referral:** mm / dd / yy

❑ Day Program: ◯ Wellness ◯ Recovery ❑ Brief Therapy Clinic: ◯ Individual ◯ Group ◯ Couple

❑ Adult Crisis Program (Urgent Clinic) ❑ Schizophrenia Clinic ❑ Discharge Clinic ❑ ECT *Specify:* _____

CLIENT/PATIENT INFORMATION

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

Patient Address: Street Number + Name Apartment City Province Postal Code

Home Phone Number: ❑ can call this number ❑ can leave messages ❑ on voicemail ❑ with person

Alternate Phone Number: ❑ can call this number ❑ can leave messages ❑ on voicemail ❑ with person

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

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

Relationship to Patient:

Home Phone Number: ❑ can call this number ❑ can leave messages ❑ on voicemail ❑ with person

Alternate Phone Number: ❑ can call this number ❑ can leave messages ❑ 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)* ATTACH/OR FAX SRHC MD 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_13 (06/15) "Adult Outpatient Mental Health" Review (06/18)