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

Rapid Assessment for Psychopharmacologic Treatment (RAPT) Referral Form

Phone: 905-895-4521, ext. 5318 Fax: 905-830-5987

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

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

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

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

Relationship to Patient: **Phone Number:**

REFERRAL INFORMATION

Psychiatric Diagnosis: _____

Reason for Referral: _____

_____

_____

Patient is presenting with a primary diagnosis of: *(check all that apply)*

❑ Anxiety disorder: *(please specify)* _____

❑ Mood disorder: ❑ Depression ❑ Bipolar Disorder _____

❑ Schizophrenia: _____

❑ Schizo-affective disorder: _____

❑ Other: *(please specify)* _____

Please complete checks to ensure that criteria for RAPT service is met:

❑ Patient is age 18-65 and DOES NOT have an existing psychiatrist

❑ Patient is acutely distressed and has a need for medication adjustment and short term follow up

❑ Patient does not need hospitalization (i.e., is not acutely suicidal)

❑ Patient is not seeking psychotherapy or any long term care (RAPT focus will be on medication management and short term collaborative care – please see cover page)

❑ Patient is not looking for assessment for legal, workplace or insurance purposes

❑ **Patient must be registered at referring family practice clinic**

INCOMPLETE FORMS WILL NOT BE PROCESSED

SL1406_12 (09/14) "Adult Outpatient Mental Health" Review (09/17)

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PAST PSYCHIATRIC/ADDICTIONS HOSPITALIZATIONS (attach discharge summaries, if available)

Facility	Dates	Reason	Duration

CURRENT COMMUNITY AGENCIES/SUPPORT Please check all that apply *(support currently receiving)*

❑ CMHA ❑ Loft/Crosslinks (housing support) ❑ Addiction Services York Region ❑ Therapist/Counselor ❑ Support group
❑ Brief Therapy Clinic ❑ Urgent Clinic ❑ Other Southlake Services: *(please specify)* _____

RELEVANT MEDICAL/MENTAL HEALTH HISTORY

Past Mental Health History/Substance Abuse History (attach previous consults, reports, relevant lab reports):

_____

_____

_____

_____

Relevant Medical History: _____

_____

_____

_____

_____

Allergies: _____

Relevant lab results: ❑ Yes, attached ❑ Yes, faxed ❑ No

PREVIOUS MEDICATION TRIALS

Name of Drug	Dose	Date of Trial	Duration of Trial	Response (Efficacy and Side Effects)

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CURRENT MEDICATIONS *(Psychiatric and Non-Psychiatric)*

MEDICATION	DOSE/FREQUENCY/ROUTE	START DATE	DATE OF LAST DOSE	RESPONSE/ADVERSE EVENTS

BY SIGNING THIS FORM, I CONFIRM THAT THIS PATIENT IS AWARE OF THIS REFERRAL

REFERRING SOURCE INFORMATION

Referred by: *Check (✓) one*

❑ Family Physician ❑ Nurse Practitioner ❑ Other *(specify)* _____

Name of Family Practice Clinic:

Referring Name: *(print first, last)* **Billing #:**

Referring Signature: **Date of Referral:** mm / dd / yy

Phone Number: **Fax Number:**

THIS SECTION ONLY TO BE COMPLETED BY SRHC STAFF

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