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

The Rapid Assessment for Psychopharmacologic Treatment (RAPT) Clinic offers consultation for Mental Health patients under the care of a family doctor who would benefit from psychiatric medication review.

Referrals can be accepted from Family Doctors affiliated with Southlake Regional Health Centre. Patients must be receiving regular follow-up with the referring Family Doctor, and must meet the RAPT referral criteria as listed below.

The clinic will offer timely psychiatric consultation and limited short term follow up (maximum two months duration) with a Psychiatrist and RAPT Nurse who will liaise with the patient's Family Physician to provide assessment and treatment recommendations. The RAPT Clinic does not offer long term follow-up, although it can help with community linkages for the follow up.

We are <u>NOT</u> able to accept referrals for assessments/treatment where concerns are related principally to:

- Adult ADHD
- Anger management
- Autism Spectrum Disorders
- Chronic pain
- Developmental delay
- Eating disorder
- Primary Substance Abuse
- Relationship counselling
- Primary Issues R/T Personality Disorder (i.e. anger management)

RAPT Clinic does not provide assessments or documentation for legal, insurance, CAS, or WSIB purposes.

Please ensure the following criteria are met: *Check (✔) all that apply*

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

❑ Patient 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 and regularly followed by referring family Physician or Nurse Practitioner**

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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)* _____

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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

CURRENT MEDICATION *(Psychiatric and Non-Psychiatric)*

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

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PREVIOUS MEDICATIONS *(Trials)*

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

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 SOUTHLAKE 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:** _____

INCOMPLETE FORMS WILL NOT BE PROCESSED

SL1406_14 (11/15) "Adult Outpatient Mental Health" Review (11/18)