



Health Record #: _____	Complete or place barcoded patient label here
Patient Name: <i>(Print first, last)</i> _____	
DOB: <u>mm</u> / <u>dd</u> / <u>yy</u>	Age: _____ <input type="checkbox"/> Female <input type="checkbox"/> Male
OHIP #: _____	Version Code: _____
Account #: _____	Date of Admission: <u>mm</u> / <u>dd</u> / <u>yy</u>

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 NOT able to accept referrals for assessments/treatment where concerns are related principally to:

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

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





596 Davis Drive
Newmarket, ON L3Y 2P9

Mental Health Program

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CLIENT/PATIENT INFORMATION					
Patient Name: <i>(print first, last)</i> _____			Date of Birth: <u>mm</u> / <u>dd</u> / <u>yy</u>		
Patient Address: Street Number + Name _____		Apartment _____	City _____	Province _____	Postal Code _____
Home Phone Number: _____		<input type="checkbox"/> can call this number	<input type="checkbox"/> can leave messages	<input type="checkbox"/> on voicemail	<input type="checkbox"/> with person
Cell Phone Number: _____		<input type="checkbox"/> can call this number	<input type="checkbox"/> can leave messages	<input type="checkbox"/> on voicemail	<input type="checkbox"/> with person
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Health Card #: _____		Version Code: _____		
Name of Emergency Contact: <i>(print first, last)</i> _____					
Relationship to Patient: _____			Phone Number: _____		
REFERRAL INFORMATION					
Psychiatric Diagnosis: _____					
Reason for Referral: _____ _____ _____					
Patient is presenting with a primary diagnosis of: <i>(check all that apply)</i>					
<input type="checkbox"/> Anxiety disorder: <i>(please specify)</i> _____					
<input type="checkbox"/> Mood disorder: <input type="checkbox"/> Depression <input type="checkbox"/> Bipolar Disorder _____					
<input type="checkbox"/> Schizophrenia: _____					
<input type="checkbox"/> Schizo-affective disorder: _____					
<input type="checkbox"/> Other: <i>(please specify)</i> _____					



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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 <i>(Trials)</i>				
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: _____