Soldiers' MEMORIAL HOSPITAL Orillia

170 Colborne Street, W.
Orillia, Ontario
L3V2Z3
Phone: 705-325-2201
Fax: 705-330-3221

Mental Health Outpatient Services Referral Form

Out-Patient Referral/Psychiatric Consult Request
By Appointment Only

Date of Referral_____

Patient Information

Patient Name:		**Patient Preferred Name:**
Patient DOB:		**WSIB No. if applicable:**
Primary Phone #:		**Alt Phone #:**
Health Card # & Version Code:		**Messages Permitted on Voicemail? Y ☐ N ☐**
E-mail Address:		

Gender: ☐ Female ☐ Male ☐ Intersex ☐ Trans (male to female) ☐ Trans (female to male) ☐ Two Spirit _____

Is patient agreeable to referral: ☐Yes ☐No (If no, please do not proceed with referral)

Marital Status: ☐Single ☐Divorced ☐Married ☐Separated ☐Widowed ☐_____

Service Requesting

☐ **Psychiatric Consult (Ages 16+) - Tel: 705-325-2201 ext. 6415**

☐**Medication Review** ☐**Short Term Management** ☐**Diagnostic Clarification** ☐**ECT Treatment**

☐**Other Program Listed Below**

☐ **Mental Health Day Hospital/Acute Outpatient Services - Tel: 705-325-2201 ext. 6395**

Acute Outpatient Services provides short-term clinical intervention to clients aged 18+ who are experiencing depression, anxiety, panic attacks, loss/grief, and major life changes including situational or psychosocial difficulties. Clients must be able to engage in treatment and be self-directed towards change. Cognitive Behavioural Therapy (CBT) is offered along with education around healthy lifestyle engagement. Clients will be assessed for individual therapy and or/group programming (including our three week daily, Day Hospital Programming).

*All Referrals will be screened for Eligibility. Referrals for assessment/treatment where the **PRIMARY** concerns are related to the following will **not** be accepted at this time: Anger Management, Eating Disorders, Chronic Pain, Relationship Counselling, Autism Spectrum Disorders, Developmental Delay and Addictions. We do not provide assessments for legal, insurance, custody, child welfare, WSIB, or forensic reasons.*

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☐**Community Mental Health Services (CMHS) - Tel: 705-325-2201 ext. 3122**

CMHS is a voluntary, extended term service that aims to provide integrated community care and support for individuals aged 16 and older with a serious mental illness (defined by diagnosis, chronicity and level of function).

Counselling and Treatment can include the following modalities: Mindfulness and Cognitive Behavioural Therapy (CBT), Dialectical Behavioural Therapy (DBT), treatment of trauma, and/or perinatal mood support.

Case Management is geared primarily towards those with a psychotic disorder requiring support and assistance with independent living skills. Case Management clients may be assessed for membership at the Meeting Place, which is an independent, peer-support clubhouse directed by CMHS clients and supported by CMHS staff.

*All Referrals will be screened for Eligibility. Referrals for assessment/treatment where the **PRIMARY** concerns are related to the following will **not** be accepted at this time: Anger Management, Eating Disorders, Chronic Pain, Relationship Counselling, Autism Spectrum Disorders, Developmental Delay and Addictions. We do not provide assessments for legal, insurance, custody, child welfare, WSIB, or forensic reasons.*

Referral Information

Reason for referral: (Goals for referral, relevant psychiatric history)

Psychiatric Symptoms

☐**Fluctuations in Mood (mood swings)** ☐**Obsessive compulsive symptoms** ☐**Elevated mood**

☐**Depressed mood** ☐**Sleep disturbance** ☐**Personality Traits** ☐**Substance Use**

☐**Confusion** ☐**Delusions** ☐**Hallucinations** ☐**Attention deficit/hyperactivity**

☐**Panic symptoms or attacks** ☐**Abnormal eating behaviours** ☐**Memory impairment**

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Psychosocial Issues

☐**Past Substance Use** ☐**Current Substance Use** ☐**Lack of social supports/isolation**

☐**Past History of Emotional/Physical/Sexual Abuse** ☐**Current Emotional/Physical/Sexual Abuse**

☐**Self Esteem** ☐**Financial** ☐**Housing** ☐**Parenting** ☐**Employment**

☐**Separation/Divorce**

Treatments

Treatment and Recovery History: (Current and previous therapy, groups, programs)

Substance Use

Substance Use: (Current substances, amount, frequency)
Does patient want help with this issue? ☐ Yes ☐ No

Medication List

(Include prescription, vitamins, over the counter medications, and herbal supplements)

Medication	Dose/Units	Route	Frequency	Instruction/Comments

How are Medications Funded:

☐**Ontario Disability Support Program** ☐ **Ontario Works** ☐**Private Insurance** ☐**Self-Pay**

☐**WSIB** ☐**Other** _____

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Legal Involvement

Current Charges ☐Yes ☐No **Probation ☐ Yes ☐No**

Community Treatment Order ☐Yes ☐No **Expiry Date (dd/mm/yyyy):**

Current Patient Risks

Risk of Harm:

☐Self ☐Others

Other Risks:

Other Stressors not Already Listed:

Referring Source Information

Referred by: ☐ Family Physician
☐ Psychiatrist
☐ Nurse Practitioner

_____
Referring clinician name

Signature

_____
Billing Number

_____
Telephone **Fax**

Stamp/Label here if applicable

Please fax Referral to (705) 330-3221