Soldiers' MEMORIAL HOSPITAL Orillia

170 Colborne Street, W.
Orillia, Ontario
L3V2Z3
Phone: 705-325-2201 x6415
Fax: 705-330-3221

Mental Health Outpatient Services Referral Form

By Appointment Only

Adult Out-Patient Referral/Psychiatric Consult Request **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:		**Address:**

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

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

☐**Fluctuation 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/isolated

☐Emotional/Physical/sexual abuse in past ☐Current emotional/physical/sexual abuse

☐Self Esteem ☐Financial Issues ☐Housing ☐Parenting Issues ☐Work issues ☐ 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 medications are funded:

☐Ontario Disability Support Program/Ontario Works ☐Private Insurance ☐Self-Pa

Legal Involvement

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

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

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Current Patient Risks

Risk of Harm (self and/or other):

Current Levels of Stressors:

Referring Source Information

Referred by: ☐ **Family Physician**
☐ **Psychiatrist**
☐ **Nurse Practitioner**

_____
Referring clinician name

_____
Billing Number

_____
Telephone **Fax**

Stamp/Label here if applicable