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 ☐Common Law ☐Separated ☐Widowed		

Service Requesting

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

☐Medication Review ☐Short Term Management ☐Diagnostic Clarification

☐Peer Support ☐ECT Treatment

☐ 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 fax :705-325-0450

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). We have three programs within CMHS that are described below in more detail.

☐**Counselling and Treatment**

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

☐**Intensive Case Management**

- Intensive Case Management is geared primarily towards those with a psychotic disorder requiring support and assistance with independent living skills.

☐**Regional Perinatal Mental Health Program**

- The program is intended for individuals 16 years of age or older who are preconception, pregnant or within one year postpartum and at risk of developing psychiatric problems and/or have a history of mental illness and/or experiencing postpartum mood disorders, anxiety disorders, psychotic disorders, or complicated perinatal related bereavement (up to one year after loss) or birth trauma. Services offered include clinical mental health assessments, counselling, psychotherapy, case management, and educational services to clients and families in the Central Region North in person and virtually.

  ☐ Pre-Conception

  ☐ Pregnancy

  ☐ Post-Partum

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Referral Information

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

Psychiatric Symptoms

☐ Fluctuation mood(mood swings)
☐ Depressed mood
☐ Substance Use
☐ Hallucinations
☐ Panic symptoms or attacks
☐ Abnormal eating behaviours

☐ Obsessive Compulsive Symptoms
☐ Sleep Disturbance
☐ Confusion
☐ Anxiety
☐ Memory Impairment
☐ Attention Deficit/Hyperactivity

☐ Elevated Mood
☐ Personality Traits
☐ Delusions
☐ Trauma
☐ Abnormal Eating Behaviours

Psychosocial Issues

☐ Past Substance Use
☐ Emotional/Physical/Sexual Abuse in past
☐ Self Esteem
☐ Separation/Divorce

☐ Current Substance Use
☐ Current Emotional/Physical/Sexual Abuse
☐ Financial Issues

☐ Lack of Social Supports/Isolated
☐ Parenting Issues
☐ Employment
☐ Housing

Treatments

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

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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):**

Current Patient Risks

Risk of Harm (self and/or other):

Current Levels of Stressors:

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Referring Source Information

Referred by:

- ☐ **Family Physician**
- ☐ **Psychiatrist**
- ☐ **Nurse Practitioner**
- ☐ **Obstetrics**
- ☐ **Midwife**
- ☐ **Other**

Referring Clinician Name

Signature

Billing Number

Telephone **Fax**

Stamp/Label here if applicable