

Phone: 705-325-2201x6415 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 t	o referral: □Yes □No If no, pl	ease do not proceed with referral			
Marital Status □ Sin	gle □Divorced □Married □Co	ommon Law □Separated □Widowed			
Service Requesting					
☐ Psychiatric Consu	ılt (Ages 16+) - Tel: 705-325-22	01 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 *					







Community Mental Health Services (CMHS) Tel: 705-325-2201 ext. 3122 fax :705-325-0450

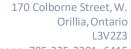
Community Mental Health Services (CMHS) Tel: 705-325-2201 ext. 3122 Tax :705-325-0450				
CMHS is a voluntary, extended term service that aims to provide integrated community care and support for individuals aged 16 and older with a serious mental illness (defined by diagnosis, chronicity and level of 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				
All Referrals will be screened for Eligibility. Referrals for assessment/treatment where the PRIMARY concerns are related to the following will <u>not</u> 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		□ Trauma				
	•	☐ Abnormal Eating				
□ Panic symptoms or attacks	□ Memory Impairment	Behaviours				
□ Abnormal eating behaviours □ Attention Deficit/Hyperactivity						
	Psychosocial Issues					
□ Past Substance Use	□ Current Substance Use	☐ Lack of Social Supports/Isolated				
☐ Emotional/Physical/Sexual Abuse in past	□ Current Emotional/Physical/Sexual	☐ Parenting Issues				
☐ Self Esteem	Abuse	□ Employment				
☐ Separation/Divorce	□ Financial Issues	□ 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 $\hfill \square$ Yes $\hfill \square$ 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 Disabilit	y Support Program	/Ontario Works	☐Private Insur	ance □Self-Pa		
Legal Involvement						
Current Charges □Yes □No Probation □ Yes □No				s□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:						







Referring Source Information				
Referred by: Family Physician Psychiatrist Nurse Practitioner Obstetrics Midwife Other				
Signature	Stamp/Label here if applicable			
Billing Number				
Telephone Fax				