Internal Use Only
Referral Date: ____ (MM/DD/YYYY)
Intake Date/Time: (MM/DD/YYYY) (HH:MM)
Assigned Worker: ____

CONCURRENT PROGRAM – REFERRAL FORM
OUTPATIENT MENTAL HEALTH SERVICES

Phone: 519-257-5125 **Fax: 519-257-5296**

Last: ____ First: ____

D.O.B.: ____ (MM/DD/YYYY) Gender: ☐ Male ☐ Female

Address: ____ City: ____

P.C.: ____ Health Card # ____ VC: ____

Phone No: ____ Emergency Contact: ____
(Name, Relationship & Phone)

****PHYSICIAN / PSYCHIATRIST INFORMATION REQUIRED** (SEE SECTION(15))**

NOTE – INCOMPLETE FORMS WILL BE DIRECTED BACK TO SOURCE
Admission Criteria:

FAMILY PHYSICIANS: PLEASE COMPLETE INFORMATION BELOW AND PROVIDE REQUESTED ATTACHMENTS
PSYCHIATRISTS: 1. Please also complete page 2
2. Program does not provide ongoing psychiatric follow-up following discharge

1. **Provisional DSM-V Diagnosis, if available:** ____
2. **Duration of Psychiatric Symptoms:** ☐ Recently ☐ Duration < 2 years ☐ Duration 2 years or more
   Past Suicidal Behaviour? If yes, please explain.
3. **Current MEDICATIONS:** DOSAGE:
4. **Physical health/conditions:**
5. **Is patient currently seeing a psychiatrist?** If yes, who? ____ Next Appt. Date: ____
   If Previously, who/when? ____
   (Please forward any psychiatric reports, consultations, discharge reports as applicable)
6. **Past PSYCHIATRIC Hospitalization:** ☐ No ☐ Yes If yes, please indicate hospital and approximate date
7. **Describe nature and extent of client's substance use. Is client also compulsive gambler?** ☐ No ☐ Yes
   Does client recognize they have a problem? ☐ No ☐ Yes
8. **Current involvement with any other mental health/counselling services?**
9. **Any barriers to communication?** ☐ No ☐ Yes

PHYSICIAN REFERRAL FORM
CONCURRENT DISORDER PROGRAM
OUTPATIENT MENTAL HEALTH SERVICES

Phone: 519-257-5125 **Fax: 519-257-5296**

Client Name: ______________________________

D.O.B.: __________ (MM/DD/YYYY) __________

PLEASE INCLUDE COPIES OF ANY PSYCHIATRIC REPORTS COMPLETED IN RECENT YEARS (if available).

10. Client's primary psychiatric diagnosis and co-morbidities (including addictions and pain disorders) (if applicable):

11. What is the goal of this referral? What is it that you are expecting to be accomplished?

12. What medications have been tried and with what results? (If not complete on previous page)

13. What type of psychotherapy has been tried? (Individual, group, self-help, etc.)

TO BE COMPLETED BY PRIMARY CARE PHYSICIANS AND/OR PSYCHIATRISTS

14. (a) ☐ **I am agreeable to a 1X consultation with the program psychiatrist**

☐ **I am agreeable to having the program psychiatrist see this patient for the program duration, with the understanding that treatment changes may occur**

Length of time as care provider for this patient: ______________________________

(b) Our program does NOT provide on-going psychiatry follow up upon program completion and patient will be returned to your care. Are you agreeable to this?

☐ No ☐ Yes If no, why?

Referring Doctor or NP: ____________________ Family Doctor: ____________________

Address: ____________________ Address: ____________________

Physician No.: ____________________ Physician No.: ____________________

Phone No.: ____________________ Phone No.: ____________________

Referring Doctor's Signature: ______________________________