HÔTEL-DIEU GRACE HEALTHCARE
ESTD 1888

500 Ouellette Avenue
Windsor, ON N9A 1B7
Phone: 519-257-5111 Ext. 72675
Fax: 519-973-1731

Client Name: ______________________

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

Healthcard #: ______________ VC ____

INTAKE / REFERRAL FORM
INJECTION CLINIC
OUTPATIENT MENTAL HEALTH

Allergies: ____

☐ ODSP: ☐ Yes ☐ No If No, Other Insurance Provider: ____________________

Discharge/Community Psychiatrist: ____________________________________

Community Treatment Order: ☐ Yes ☐ No If Yes, Worker's Name: ________________

Last Injection Date: ____ (MM/DD/YYYY) ____ Next Injection Due Date: ____ (MM/DD/YYYY) ____

For successful intake, please provide the following, in addition to this referral, by fax to 519-973-1731

Some of the following documents are only applicable to hospital encounters.

1. Face Sheet
2. Psychiatry Consult
3. History & Physical
4. Discharge Summary
5. **Prescription for LAI or Clozapine (with repeats)**

If patient is being referred for Clozapine, please also attach the following:

6. Copy of last CBC result
7. Monitoring frequency of CBC ☐ Q1W ☐ Q2W ☐ Q4W

Upon faxing the above stated documentation, please call to arrange appointment
at 519-973-4411 Ext. 72675.

∗ Please note that clients must be discharged with enough Clozapine to accommodate the time frame between discharge and their first clinic visit.*

Referral Source: ____________________ Contact Name: ________________________

For Office Use Only:

Appointment Date: ______ (MM/DD/YYYY) ______ **Time:** ____ (HH:MM) ____