Hôtel-Dieu Grace Healthcare

PHYSICIAN REFERRAL FORM
MOOD AND ANXIETY TREATMENT PROGRAM
OUTPATIENT MENTAL HEALTH SERVICES

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

Referral Date: _____ (MM/DD/YYYY)

Intake Date/Time: _____ (MM/DD/YYYY) (HH:MM)

Intake Worker: _____

Last (Maiden): _____ **First:** _____ **Gender:** ☐ **Male** ☐ **Female**

Address: _____ **City:** _____ **P.C.:** _____

Phone No: _____ **Work/Cell No:** _____

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

PHIN: _____ **Version:** _____

EMERGENCY CONTACT (Name, relationship & phone)

_____

Ref.Dr.: _____ Fam.Dr.: _____

Address: _____

Physician No.: _____ Phone: _____

Physician's Signature: _____

Admission Criteria: NOTE – INCOMPLETE FORMS/referrals NOT MEETING CRITERIA will be directed back to source

- Primary diagnosis of a complex, treatment resistant/refractory mood and/or anxiety disorder
- Severe range of symptoms, chronic duration, impairment in social/occupational functioning, risk of harm
- Documentation of failure to respond to primary care interventions, ie., no success with medications/therapy

PSYCHIATRISTS: Please also complete page 2

1. Reason/Goal for Referral: _____

_____

Provisional DSM-IV-TR Diagnosis, if available: _____

2. Severity of client's psychiatric symptoms – Global Assessment of Functioning (please check ONE):

[ ] 61-70 Some mild symptoms OR some difficulty in social, occupational or school functioning; generally functioning well
[ ] 51-60 Moderate symptoms OR any moderate difficulty in social, occupational or school functioning
[ ] 41-50 Serious symptoms OR any serious impairment in social, occupational or school functioning
[ ] 31-40 Some impairment in reality testing or communication OR major impairment in several areas - work, school, family judgment, thinking, or mood
[ ] 21-30 Behaviour is considerably influenced by delusions or hallucinations OR serious impairment in communications or judgment OR inability to function in all areas
[ ] 11-20 Some danger of hurting self or others OR occasionally fails to maintain minimal personal hygiene OR gross impairment in communication

3. Duration of Psychiatric Symptoms: ☐ Recently ☐ Duration < 2 years ☐ Duration 2 years or more

4. Current MEDICATIONS including DOSAGE and DATES INITIATED (attach additional pages as necessary)

5. Previously tried medications including dosages and responses (ie., partial, none, side-effects)**:**

6. Is patient currently seeing a psychiatrist? If yes, who? _____
(Please include any psychiatric reports, consultations, discharge reports as applicable)

7. Past PSYCHIATRIC Hospitalization: ☐ No ☐ Yes If yes, please include hospitalization records

8. Patient has a substance abuse problem: ☐ No ☐ Yes If yes, Please explain _____

9. Current involvement with any of the following? (please circle all that apply)

HDGH CMHA CAS RCC EAP Self Help Private Therapy WSIB Insurance Claims Disability Other

For Office Use Only:
FINAL DISPOSITION: ☐ Re-referral from _____ ☐ Re-Admit

☐ Date Opened _____ (MM/DD/YYYY) Assigned to: _____

☐ Date Closed _____ (MM/DD/YYYY) Referred to: _____

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Client Name: _____

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

PLEASE INCLUDE COPIES OF ANY PSYCHIATRIC REPORTS COMPLETED IN RECENT YEARS.

10. Length of time as care provider for this patient: _____

11. Patient's primary psychiatric diagnosis and co-morbidities (including addictions and pain disorders):

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

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

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