

ADULT REFERRAL – INFORMATION AND INSTRUCTIONS

STEP 1 – BEFORE COMPLETING THE REFERRAL FORM

Go to www.camh.net for detailed information on each program.

physician referral is required by the following programs and services		
▪ CATS Program / General Psychiatry	▪ Mood and Anxiety Program	▪ Women's Mental Health Program
▪ Memory Clinic, Geriatric Mental Health Program	▪ Sexual Behaviours Clinic, Law and Mental Health Program	▪ Telepsychiatry – Northern Psychiatric Outreach Program (NPOP-C)
for all other CAMH programs, physician referral is not required		

For Addictions Program Services **do not complete this form**. Client/Patient **must call** 416-535-8501 x 6616.

For inquiries with respect to private assessments (independent medical examinations), contact must be made directly with the clinician involved.

This is not a crisis or emergency referral service. For emergencies you may call TeleHealth: 1-866-797-0000 and TTY is 1-800-387-5559; call 911; or proceed to your nearest Emergency Room.

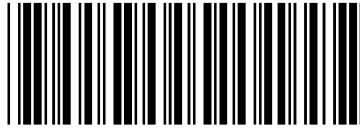
STEP 2 – COMPLETING THE REFERRAL FORM

- Include **all known information** relevant to this referral.
- Use space available on the last page to provide additional or clarifying information.
- Include any relevant **lab results**, especially drug levels (**e.g. 12 hour trough for mood stabilizers**), **medical reports**, **medication sheet**, **physical lab findings**, **psychological reports**, and copies of **previous psychiatric consultations or discharge summaries**, along with a signed **consent for disclosure of personal health information**.

STEP 3 – AFTER COMPLETING THE REFERRAL FORM – FAX TO:

Fax # s for CAMH programs and services	
Centralized Assessment Triage and Support (CATS) Ambulatory Service FAX: 416-979-6815 Gender Identity Clinic FAX: 416-583-1360	Mood and Anxiety Program Outpatient FAX: 416-260-4208 Inpatient Unit FAX: 416-583-1334 ECT and rTMS consultation FAX: 416-979-6936
Dual Diagnosis Program (Intellectual disability plus mental health issues) FAX: 416-504-1272 Peel FAX: 905-568-4159	Schizophrenia Program Schizophrenia Triage, Assessment and Research Service (STARS) FAX: 416-260-4197
Geriatric Mental Health Program FAX: 416-583-1296	Women's Mental Health Program FAX: 416-979-4975
Law and Mental Health Program Sexual Behaviours Clinic FAX: 416-260-4187	Telepsychiatry – Northern Psychiatric Outreach Program (NPOP-C) – FAX: 416-260-4186

<p>Not sure where to send the referral? Contact CATS: Tel: 416-979-6878 Fax: 416-979-6815</p>
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* D 0 2 4 2 A *

for CAMH use:
Client/Patient ID Label

ADULT REFERRAL

Date of Referral: _____
(dd/mm/yyyy)

Use last page to provide additional information

Client/Patient Information	Referring Source Information
<p>Legal Name: _____ (last name, first name)</p> <p>Preferred Name (if applicable): _____</p> <p>Date of Birth: _____ Age: _____ (dd/mm/yyyy)</p> <p>Sex/Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Intersex <input type="checkbox"/> Transgender <input type="checkbox"/> Transsexual</p> <p>Telephone number(s) (specify home, office, cell, etc.) Tel: _____ Tel: _____</p> <p>Can confidential message be left on client/patient voicemail? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Can confidential message be left with family? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Address: _____ _____</p> <p>Can appointment letter be sent to this address? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, specify how client/patient prefers to be contacted: _____</p> <p>Health Card #: _____ Version code: _____</p> <p>Next of Kin: _____ (last name, first name)</p> <p>Substitute Decision Maker (if different from Next of Kin): _____ (last name, first name)</p> <p>Relationship to client/patient: _____</p> <p>Address: _____ _____</p> <p>Tel: _____</p>	<p>Name: _____ (last name, first name)</p> <p>Check one: <input type="checkbox"/> Family Physician <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other (specify) _____</p> <p>Tel: _____ Fax: _____</p> <p>Address: _____ _____ _____</p> <p>Billing Number (if referred by physician): _____</p> <p>Is client/patient's current psychiatrist aware of referral (if not referred by a psychiatrist)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Does not have psychiatrist</p> <p>Name of Psychiatrist (if applicable): _____ (last name, first name)</p> <p>Does the referring source wish to receive a consultation report? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Is client/patient (or substitute decision maker) aware of and in agreement with the referral and that he/she will be seen? (check one): <input type="checkbox"/> Yes <input type="checkbox"/> No (If No, please explain): _____</p> <p>Is there a need for an interpreter (e.g., for sign language or other language)? <input type="checkbox"/> No <input type="checkbox"/> Yes (please specify): _____</p> <p>Are there any other barriers to communication and/or accessibility with this client/patient? <input type="checkbox"/> No <input type="checkbox"/> Yes (please specify): _____</p>	

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(last name, first name)

Date of Referral: _____
(dd/mm/yyyy)

Use last page to provide additional information

1. REASON FOR REFERRAL

Diagnostic clarification
 Medication review
 Treatment resistance
 Other

Please specify:

2. WORKING DIAGNOSIS/CLINICAL PROBLEM(S)

WORKING DIAGNOSIS (CHECK ALL THAT APPLY)	SPECIFY <u>CURRENT</u> CLINICAL PROBLEMS	RELEVANT HISTORY												
Anxiety <input type="checkbox"/>	<input type="checkbox"/> Social <input type="checkbox"/> Panic <input type="checkbox"/> OCD <input type="checkbox"/> Generalized													
Bipolar <input type="checkbox"/>	<input type="checkbox"/> Mania <input type="checkbox"/> Depression <input type="checkbox"/> Mixed Episode <input type="checkbox"/> First Episode Mood with Psychosis													
Depression <input type="checkbox"/>	<input type="checkbox"/> Hallucinations <input type="checkbox"/> Delusions													
Dementia <input type="checkbox"/>	<input type="checkbox"/> Memory Issues													
Dual Diagnosis (Intellectual disability plus mental health issues) <input type="checkbox"/>	<input type="checkbox"/> Suspected <input type="checkbox"/> Requesting Confirmation <input type="checkbox"/> Confirmed If confirmed, specify level of intellectual disability as diagnosed by a licensed psychologist: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe													
Problem Gambling <input type="checkbox"/>	Does the client/patient want to address gambling-related concerns? <input type="checkbox"/> No <input type="checkbox"/> Yes													
Schizophrenia / Spectrum Illness <input type="checkbox"/>	<input type="checkbox"/> Hallucinations <input type="checkbox"/> Delusions <input type="checkbox"/> First Episode Psychosis													
Substance Use <input type="checkbox"/>	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 33%;">Substance</th> <th style="width: 33%;">Amount</th> <th style="width: 33%;">Frequency</th> </tr> </thead> <tbody> <tr> <td style="border: 1px solid black; height: 20px;"></td> <td style="border: 1px solid black; height: 20px;"></td> <td style="border: 1px solid black; height: 20px;"></td> </tr> <tr> <td style="border: 1px solid black; height: 20px;"></td> <td style="border: 1px solid black; height: 20px;"></td> <td style="border: 1px solid black; height: 20px;"></td> </tr> <tr> <td style="border: 1px solid black; height: 20px;"></td> <td style="border: 1px solid black; height: 20px;"></td> <td style="border: 1px solid black; height: 20px;"></td> </tr> </tbody> </table> Does the client/patient want to address his/her substance use? <input type="checkbox"/> (check if yes)	Substance	Amount	Frequency										
Substance	Amount	Frequency												
Known history of trauma <input type="checkbox"/>	Please specify:													
Known history of personality disorder <input type="checkbox"/>	Please specify:													

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Use last page to provide additional information

3. RISK ISSUES

RISK ISSUE	CHECK IF YES	IF YES: WHEN?	DETAILS
Suicide attempt/ideation			
Deliberate self-harm			
Violent behaviour			
Legal involvement			
Addictions issues			
Behavioural issues			
Swallowing problems			
Other (e.g. falls, fire starting, wandering)			

4. CURRENT MEDICATIONS (Psychiatric and Non-Psychiatric) *attach additional information if needed*

MEDICATION	DOSE / FREQUENCY	RESPONSE & ADVERSE EFFECTS

5. PAST MEDICATIONS (Psychiatric and Non-Psychiatric)

MEDICATION	DOSE / DURATION	RESPONSE & ADVERSE EFFECTS

6. CURRENT and PAST PSYCHOTHERAPIES OR OTHER THERAPIES (including alternative therapies)

THERAPY	WHEN / DURATION	OUTCOME/COMMENTS

7. PAST PSYCHIATRIC/ADDICTIONS HOSPITALIZATIONS (attach discharge summaries)

FACILITY	DATES (dd/mm/yyyy)	REASON

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8. RELEVANT MEDICAL HISTORY (e.g. endocrine, neurological, respiratory, cardiac, or other issues)

[Empty box for medical history]

9. KNOWN ALLERGIES

[Empty box for allergies]

10. METABOLIC ISSUES

[Empty box for metabolic issues]

ADDITIONAL INFORMATION

(e.g. client/patient strengths, current and/or past medications; additional medical history; other comments)

[Empty box for additional information]

Completed by:

(print name and credentials)

(signature)

Date: _____
(dd/mm/yyyy)

At CAMH we integrate clinical care and research to improve the prevention, diagnosis and treatment of mental health and addiction disorders. Clients/Patients are key to this goal and may be invited to participate in research.