

**MARY MCGILL COMMUNITY MENTAL HEALTH PROGRAM
OUTPATIENT REFERRAL**

Our outpatient Mental Health Program accepts referrals where there is a primary Psychiatric concern. We provide CONSULTATION ONLY. Upon receipt of your completed referral our team will review and determine how best to serve your patient. If appropriate, they will be contacted to complete the screening process. Referrals that are not completed will be returned.

CLIENT/PATIENT INFORMATION:			
Last Name	First Name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	
Address (street)			
City/Town		Postal Code	
Home Phone #		Cell #/Other	
Date of Birth (yyyy/mm/dd)	Health Card Number	Version Code	
Is the patient aware and supportive of this referral? <input type="checkbox"/> Yes <input type="checkbox"/> No			

ALL REFERRALS WILL BE SCREENED FOR APPROPRIATENESS

We are NOT able to accept referrals for Assessment where concerns are related primarily to: Legal, Insurance, Custody, Children's Aid Society (CAS), Workplace Safety and Insurance Board (WSIB) or Forensic reasons.

SERVICE REQUEST: Psychiatry Consultation Referral to Individual Counselling Groups Crisis

Clinical Features: (Please check all that apply)

<input type="checkbox"/> Depression/Mood Symptoms	<input type="checkbox"/> Inability to cope with life stressors
<input type="checkbox"/> Manic/hypomanic Symptoms	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Panic Attacks	<input type="checkbox"/> Hallucinations/delusions
<input type="checkbox"/> Significant Relationship problems	<input type="checkbox"/> Obsessive/Compulsive Behaviours
<input type="checkbox"/> Sleep Disturbance	<input type="checkbox"/> Decrease in self-care
<input type="checkbox"/> Hyper Deficit/Hyperactivity	<input type="checkbox"/> Other (please specify)
<input type="checkbox"/> Significant substance Use	

What? _____

How long? _____

Please Note: If primary is substance use problem, please refer to OATC Alliston, 705-250-5100

Serious Risk Factors:	Present	Past
Suicide Ideation	<input type="checkbox"/>	<input type="checkbox"/>
Suicide Attempt	<input type="checkbox"/>	<input type="checkbox"/>
Police Involvement	<input type="checkbox"/>	<input type="checkbox"/>
Violent Behaviours	<input type="checkbox"/>	<input type="checkbox"/>
Other Self Harm Behaviours	<input type="checkbox"/>	<input type="checkbox"/>

PRESENTING PROBLEM/ADDITIONAL NOTES: (Please describe in detail any clinical features or risk factors identified above)





200 Fletcher Crescent
 Alliston, Ontario L9R 1W7
 Tel: 705-435-5140
 Fax: 705-434-5150

PATIENT LABEL

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Medical Conditions:

Current Medications:

Name/Type	Dosage	When initiated

Any Adverse Drug Reactions/Known Allergies?

Mental Health Treatments and/or Psychiatric Admissions in past two years

What	Where	When
1.		
2.		
3.		

REFERRAL INFORMATION:

Family Physician/Nurse Practitioner:		Billing Number:
Phone:	Fax:	
Signature:		Date:

If you have a concern that a patient is actively suicidal please direct them to the Nearest Emergency Department.

Additional resources that may be able to accommodate more urgent referrals:
 Southlake Regional Health Centre
 Dept of Psychiatry
 905-853-3103 Ext. 2070

CMHA York/south Simcoe
 Rapid Access Psychiatry Program
rapreferral@cmha-yr.on.ca
 1-866-0183 Ext. 3321

Waypoint Centre for Mental Health – Forms can be obtained through their website.

Geriatric Psychiatry Referrals can be sent to CMHA/Loft integrated Psychogeriatric Outreach Program (IPOP) through Central Access at 1-844-798-6920.

