STEVENSON MEMORIAL HOSPITAL

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

PATIENT LABEL

MARY McGILL COMMUNITY MENTAL HEALTH PROGRAM

OUTPATIENT REFERRAL

Outpatient Referral - Fax to: 705-434-5150 *Tel: 705-434-5140*

Please print clearly and include any relevant medical/psychiatric reports or summaries.
INCOMPLETE REFERRALS WILL NOT BE PROCESSED.

Referral Date: (dd/mm/yy)

Referral Source (Name)**:**

☐ GP ☐ PSYCHIATRIST ☐ SMH RN/NP ☐ ER ☐ OTHER (specify):

Phone Fax#: Email:

Family Physician Name:

NOTE: CHOOSE SERVICE THIS REFERRAL IS INDICATED FOR:	
COUNSELLING CLINIC ☐ **Individual Counselling** ☐ **Group Counselling**	**URGENT CLINIC (counselling only)** ☐ **(Contact Main Clinic # & Fax referral)**

☐ **Psychiatric Consult / Assessment** (Referring Physician's OHIP billing **#**_____)

CLIENT / PATIENT INFORMATION			
Patient Name:			**D.O.B.** (dd/mm/yy) _____/_____/_____
Address:			
Fire #:	**Lot:**	**Conc.:**	**Township:**
Home Phone:			☐ Ok to leave a message
Cell Phone:			☐ Ok to leave a message
Bus. #			☐ Ok to leave a message
Sex: ☐ Male ☐ Female	**Health Card #:**		**Version code:**

DIAGNOSIS: Axis I _____
Axis II_____
Axis III_____

PRESENTING PROBLEM:

WE DO NOT ACCEPT REFERRALS PRIMARILY DEALING WITH COMPENSATION/INSURANCE ISSUES OR COURT ORDERED TREATMENT.

STEVENSON
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OUTPATIENT REFERRAL Continued

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Risk Issues/Any History As Follows? ☐ Yes ☐ No If Yes, when? _____
Comments:
Criminal Charges
Violent Behaviour
Suicidal Attempts
Substance Abuse Hx
Other Self Harm Behaviour

MEDICATIONS		
Psychiatric/Nonpsych.	**Dose/Frequency**	**Comments**

CURRENT AND PAST PSYCHOTHERAPIES		
Therapy	**When/Duration**	**Outcome**

FOR OFFICE USE ONLY	
Date Rec'd: (dd/mm/yy) _____/_____/_____	**Contacted:** ☐ Yes ☐ No
Phone Screen Date: _____/_____/_____	Referral Declined: ☐ By Client ☐ By Progr.
	Redirected to:
Staff name:	