

Mental Health Ambulatory Services Referral Form Phone: 705-728-9090 Psychiatry: x47210 MHA Day Program X47260

Fax: 705-739-5631

The Mental Health Ambulatory Services accepts referrals where there is a primary psychiatric concern. We provide short term consultation and stabilization for patients age 16 and above.

Referral forms that are incomplete will not be processed and will be returned. The Mental Health Ambulatory Services accepts referrals for patients living within the primary catchment of the Greater Barrie area.

Client/Patient Inform	ation						
Date patient was last s			Sex:	☐ Male ☐ Female			
·	(yyyy/mm/dd)						
Is patient agreeable to referral? ☐ Yes ☐ No If no, please do not proceed with referral							
Patient Name			Date	e of Birth (yyyy/mm/dd)			
Address							
		_					
Health card number							
		Can le	ave message?	□ Yes □No			
Provide a working pho	ne number		3				
Marital status		☐ Single	☐ Divorced	☐ Separated			
(this information is used by	the hospital to register patients) □ Married	☐ Widowed	·			
	<u>Il referrals will be s</u>						
We are NOT able to accept referrals for assessments/treatment where concerns are related							
primarily to: Anger management	Chronic pai	in	Relatio	nship counselling			
Autism spectrum disor							
We do not provide assessments for legal, insurance, custody, Children's Aid Society (CAS),							
				id Society (CAS),			
Workplace Safety and Insurance Board (WSIB) or forensic reasons Is the patient involved in current/pending legal, compensation or insurance claims? □ Yes □ No							
•			isurance ciaim	3: 1C3 1NO			
If yes, please explain:							
Service Request: Psychiatric Consult		Mental Health &	Addiction Day [Drogram			
(select one):		(select one):	Addiction Day i	riogiaili			
☐ Medication review	☐ Diagnostic clarification	☐ Mental Health	n & Addiction D	ay Program			
☐ Short-term	☐ Ontario	☐ Brief transitio	nal case manaç	gement			
management	Telemedicine Network (OTN) if available						
Reason for referral:							

RVH-1975 28 Jan 2016



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Current Medications		Past Medications Please list side effects if any/reason for discontinuation				
How medications are funded: ☐ Ontario Disability Support Program/Ont	ario Works	□ Private In	surance □ Self-Pay			
Medical Condition(s)						
☐ No known allergies Allergies:						
Psychiatric Symptoms						
☐ Fluctuating mood (mood swings) ☐ Obsessive compulsive symptoms ☐ Phobia(s): ☐ Other anxiety symptoms ☐ Attention deficit/hyperactivity	 ☐ Elevated mood ☐ Depressed mood ☐ Sleep disturbance ☐ Delusions ☐ Hallucinations ☐ Memory impairment 		 □ Personality traits □ Substance use □ Confusion □ Abnormal eating behaviours □ Panic symptoms or attacks 			
Psychosocial Issues	□ Doot o	whatanaa waa	□ Financial Issues			
 ☐ Marital/Common-law/Partner problem ☐ Lack of social supports/isolated ☐ Physical/sexual abuse in childhood ☐ Current physical/sexual abuse ☐ Sexual problem 	 □ Past substance use □ Current substance use □ Separation/divorce □ Anger/temper control □ Bereavement 		 ☐ Financial Issues ☐ Housing ☐ Parenting issues ☐ Work problems ☐ Self Esteem ☐ No employment 			
Addictions: Does the patient use illegal drugs or misus Does the patient drink alcohol? Has either caused the patient problems in Does the patient want to learn more about	their life re	ecently?	 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No 			
Referring Source Information (Referrals accepted from physician or nurse practitioner) Referred by: □ Family Physician □ Psychiatrist □ Nurse Practitioner						
Referring clinician's name		Stamp/label here if applicable				
Billing No.						
Telephone Fax						
Mental Health and Addictions Program Use Only						
Date referral received: D	ate decisio	n made or call:	Date access for service:			