Lakeridge Health

Mental Health Psychiatry
Adult (for patients 19+) Referral Form

Tel: 905−576−8711 Ext. 4588
Fax: 905−721−4761

Last Name	First Name	Address (street)	
Address (mailing address if different from above)		City/Town	Postal Code
Home Phone #	Other:	Sex ❒ Female ❒ Male D.O.B_____ DDMONYYYY	
Health Card Number: Version Code:		Is patient Aware / Supportive of this Referral? ❒ YES ❒ NO	

CLINICAL INFORMATION

Why is this patient seeking Mental Health Services?	**Reason for Referral?** ❒ Psychiatry Assessment ❒ Group Therapy ❒ Diagnostic Clarification ❒ Consultation ❒ Treatment Recommendations

CLINICAL FEATURES (Please check all that apply) **Please note: If primary is substance use problem, please refer to Pinewood 905−723−8195**

❒ Pronounced and/or resistant Depression
❒ Psychotic symptoms
❒ Manic / Hypomanic symptoms
❒ Long Standing Significant Relationship Problems
❒ Significant Substance Use
What? _____
How Often? _____

❒ Inability to cope with Life Stressors
❒ Anxiety / Panic
❒ Obsessive / Compulsive Behaviour
❒ Sexual Assault
❒ Other (please specify)_____

Serious Risk Factors:

❒ Risk of harm to self: ❒ plan ❒ intent
❒ Risk to harm others: ❒ plan ❒ intent
❒ Bizarre Behaviour
❒ Pronounced Self Neglect / problems with ADL
❒ Aggressive Behaviour ❒ YES ❒ NO
❒ Other (please specify)_____

FOR EMERGENCY SERVICES PLEASE REFER TO OSHAWA EMERGENCY DEPARTMENT/CRISIS INTERVENTION TEAM.

Additional Notes: (Please describe in detail any clinical features or risk factors identified above)

Current Medications:

	Name/Type	Dosage	When Initiated
1.			
2.			
3.			
4.			
5.			
6.			

Any adverse Drug Reactions?

Has Client been referred to other services? ❒ Yes ❒ No
If yes − Where?

Other involved Care Providers: (Case Manager, Psychologist, MH worker, etc.)

Previous/Current Treatments: (including psychiatric admissions)

	What	Where	When
1.			
2.			
3.			
4.			
5.			
6.			

Does patient have access to any of the following?
Private Counselling ❒ Yes ❒ No
Workplace EAP ❒ Yes ❒ No
Private Psychiatrist ❒ Yes ❒ No

Precipitating/Complicating Factors (e.g. compliance, social, legal, medical, unsuccessful trials of medications, etc.)

Family Physician:	Phone Number:	Billing Number:
Referring Physician:	Phone Number:	Billing Number:
Date:	Signature:	

Please Note: We do not accept referrals for WSIB, Parenting, Forensics, Fitness, Legal or any other Third Party requests.

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