Lakeridge Health

MENTAL HEALTH PSYCHIATRY ADULT REFERRAL FORM (For Patients 19+)

TEL: 905-576-8711 Ext. 4588 FAX: 905-721-4761 **Please Print Clearly or Type**

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 Day ☐ Month ☐ Year ☐	
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 Behaviours ☐
Sexual Assault ☐
Other (please specify) _____
_____
_____
_____

Serious Risk Factors:
Risk to 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.