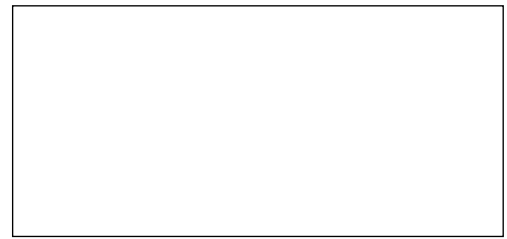




**Lakeridge
Health**

**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 <input type="checkbox"/> Female <input type="checkbox"/> Male	D.O.B. _____ <small>DDMMYYYY</small>
Health Card Number:	Version Code:	Is patient Aware / Supportive of this Referral? <input type="checkbox"/> YES <input type="checkbox"/> NO	

CLINICAL INFORMATION

Why is this patient seeking Mental Health Services?	Reason for Referral? <input type="checkbox"/> Psychiatry Assessment <input type="checkbox"/> Group Therapy <input type="checkbox"/> Diagnostic Clarification <input type="checkbox"/> Consultation <input type="checkbox"/> Treatment Recommendations
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CLINICAL FEATURES (Please check all that apply) **Please note: If primary is substance use problem, please refer to Pinewood 905-723-8195**

<input type="checkbox"/> Pronounced and/or resistant Depression <input type="checkbox"/> Psychotic symptoms <input type="checkbox"/> Manic / Hypomanic symptoms <input type="checkbox"/> Long Standing Significant Relationship Problems <input type="checkbox"/> Significant Substance Use What? _____ How Often? _____	<input type="checkbox"/> Inability to cope with Life Stressors <input type="checkbox"/> Anxiety / Panic <input type="checkbox"/> Obsessive / Compulsive Behaviour <input type="checkbox"/> Sexual Assault <input type="checkbox"/> Other (please specify) _____	Serious Risk Factors: <input type="checkbox"/> Risk of harm to self: <input type="checkbox"/> plan <input type="checkbox"/> intent <input type="checkbox"/> Risk to harm others: <input type="checkbox"/> plan <input type="checkbox"/> intent <input type="checkbox"/> Bizarre Behaviour <input type="checkbox"/> Pronounced Self Neglect / problems with ADL <input type="checkbox"/> Aggressive Behaviour <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Other (please specify) _____
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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:			Previous/Current Treatments: (including psychiatric admissions)		
Name/Type	Dosage	When Initiated	What	Where	When
1. _____			1. _____		
2. _____			2. _____		
3. _____			3. _____		
4. _____			4. _____		
5. _____			5. _____		
6. _____			6. _____		

Any adverse Drug Reactions? _____

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

Has Client been referred to other services? Yes No
 If yes – Where? _____

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

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.

