AIMHS

Adult Integrated Mental Health Services
(formerly INTERACT and Adult Outpatient Services)

The Whitby Mall
1615 Dundas Street East,
Lang Tower, 2nd Floor, Suite W214
Whitby, ON L1N 2L1
T. (905) 576-8711 ext. 36029
F. (905) 434-7716

1. CLIENT DEMOGRAPHIC INFORMATION		
Legal Name: (last name, first name):		Date of Birth: ____/____/____ (dd / mm / yy)
Preferred Name (if applicable):		Gender:
Address:		Apartment/Unit#:
City:		Postal Code:
Preferred Phone #: Ok to leave message? ☐ No ☐ Yes	Alternate Phone #: Ok to leave message? ☐ No ☐ Yes	
Health Card #:	Version Code:	Expiry:

2. REFERRAL SOURCE INFORMATION		
Referring Agent Name and/or Program:		
Address:	Unit#:	City:
Postal Code:	Phone#:	Fax#:

3. CLIENT MEDICAL INFORMATION

What is the date your client last had their complete physical? : ____/____/____ (dd / mm / yy)

Has your client been diagnosed with any significant medical conditions (such as diabetes, hypertension, thyroid, cardiac)?
☐ No ☐ Yes ☐ Currently Investigating ☐ Other _____

Is your client medically cleared to attend community based mental health treatment? ☐ No ☐ Yes

Additional Information:

Medications (psychiatric and non-psychiatric; attach additional information if needed)

Medication	Reason Prescribed	Dose & Prescribing Instructions

4. REFERRAL INFORMATION (attach additional information relevant to referral if needed)

Reason for Referral / Psychiatric Presentation:

Additional Comments:

PLEASE ENSURE YOUR CLIENT IS AWARE OF AND IN AGREEMENT WITH THIS REFERRAL

Name (Print Clearly): _____ Signature: _____ Date ____/____/____

Revised: April 10, 2019