Lakeridge Health

Lakeridge Health Ajax & Pickering Site
Mental Health Day Treatment/Day Hospital
Referral Form

Referral Date: _____

Patient's Name: _____

Address: _____

Telephone (Home)**:**_____ (Cell:)_____

DOB: _____ **Health Number:** _____

Referral Source: _____**Psychiatrist:** _____

PRIORITY: ❒ Emergent ❒ Urgent ❒ Non-Urgent

Programs:	**Clinics :**
❒ Day Hospital (3 weeks) ❒ Day Treatment (3 months) ❒ Clozaril Clinic ❒ Depot Clinic	❒ Anxiety and Panic ❒ Yoga for Depression

Relevant History: (Please attach history or use back of page re: diagnosis, length of illness, problems/stressors, abuse history, etc.)

Date Received: _____ **Assigned to**:_____

For Day Program Use Only: ❒ No Contact ❒ No Show