Mental Health Day Treatment Program (MHDT) Oshawa

1 Hospital Court,
4th floor (4A)
Oshawa, ON L1G 2B9
(905) 576-8711 ext. 34144

Referral Form
(Please print clearly)

Exclusionary Criteria:

- Active psychosis, mania, anti-social/narcissistic traits
- Substance use or dependence that may impede the treatment process
- Significant language, literacy, memory, or cognitive impairment(s)
- Developmental/intellectual disability
- Active involvement with ECT and/or recent course of ECT
- Housing and/or medical instability that may impede the treatment process

Date of Referral: _____ Unique #: _____

Name: _____ DOB: _____

Phone/Cell Number: _____

Can voice message be left on machine? Yes No

Referred by (Please Print): _____

Referral Source Contact Number: _____

Assigned Psychiatrist: _____

Diagnosis: _____

Reason for Referral / Psychiatric Presentation:
(please provide a summary of client's current mental health concerns):

_____
_____
_____
_____
_____

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Treatment Goals:

_____

_____

_____

Presenting Clinical Problems: (Please check all that apply)

- ☐ Anxiety/Panic/Phobia Disorder
- ☐ Depression
- ☐ Suicide Risk
- ☐ Personality Disorder
- ☐ Impulsivity/Aggression
- ☐ Substance use or Gambling
- ☐ Criminal Behavior
- ☐ Hallucinations/Delusions
- ☐ Homicidal Risk
- ☐ Legal Problems
- ☐ CAS Involvement
- ☐ Marital/Family Problems

Please attach the following with this referral:

( ) Consultation Note
( ) Discharge Summary (if available)
( ) Other supporting assessments or clinical information

Has this client been referred elsewhere? Yes_____ or No_____

If so, where: _____

Is the client involved with any other service? Yes___ or No___

If so, where: _____

Has client been informed regarding this referral? Yes___ or No_____