William Osler Health System

Outpatient Mental Health
(Centralized Intake and Triage)
REFERRAL FORM

Brampton Civic Hospital
Etobicoke General Hospital
Peel Memorial Centre
Community Mental Health
Phone: 905-494-6709
Fax: 905-494-6757

Patient Identification

Referral Source ◯ER/UCC ◯Acute Care ◯Primary Health Care ◯SCOPE ◯Other_____

Outpatient Mental Health program offers short term psychiatric consultation, group psychotherapy, and limited short term individual psychotherapy for patient's with mental health and/or addictions concerns. Services may be offered at any William Osler Health System site or through Queen Square Family Health Team.

INCLUSION CRITERIA
- Resides in Central West LHIN
- Provisional diagnosis of mental illness
- Valid OHIP / Interim Federal Health (IFH) Program

EXCLUSION CRITERIA
- Actively suicidal or homicidal
- Requiring crisis assessment or hospital admission
- Assessments for court purposes or forensic psychiatry
- Completion of forms for insurance or medical purposes

Patient Information

Patient's Last Name: _____ **Patient's First Name:** _____

Date of Birth: (DD/MM/YY) _____ **Gender:** ◯ **Male** ◯ **Female** ◯ **Other**

Health Card Number: _____ **Version:** _____ **No OHIP:** ☐

Address: _____ **City:** _____ **Province:** _____ **Postal Code:** _____

Phone # (primary): _____ **Phone # (alternate):** _____

☐ **Interpretation Services Required; Language:** _____

Person to contact for booking appointment & relationship to patient *(if different than patient):*

_____

Can a message be left on the phone number provided? ◯**Yes** ◯**No**
If the patient is a child, who has parental custody/guardianship?_____

Reason for Referral and Relevant Patient History

URGENCY: ◯ **Urgent** ◯ **Routine**

Has patient seen a psychiatrist in the last year? ◯**Yes** ◯**No** If yes, provide name: _____

Has patient experienced a mental health related hospital admission in the last six months? ◯**Yes** ◯**No** ◯**N/A**

Presenting Problem/Provisional Diagnosis: _____

_____

Current Medications: _____

Child Services (less than 18):
- ☐ Psychiatry Consult
- ☐ Mood and Anxiety Individual Counselling
- ☐ Mood and Anxiety Group Counselling
- ☐ Eating Disorders Clinic
- ☐ Trauma Counselling (TAY ages 16-24)

Adult Services (select all that apply):
- ☐ Psychiatry Consult
- ☐ Mood & Anxiety Group Counselling—Stepped-Care Program
- ☐ Psychosis Program (including Depot/Clozapine)
- ☐ Eating Disorders Clinic
- ☐ Addiction Counselling Services (client must be aware of the referral and agree to receiving services)

Referring Physician/Nurse Practitioner (NP) Information (please print clearly)

Referring Physician/NP Name: _____ **OHIP Billing Number:** _____

Phone #: _____ **Fax #:** _____ **E-mail:** _____

Family Physician/NP *(If different from above)*: _____

Signature of Referring Physician/NP: _____ **Referral Date:** _____