



**CONCURRENT PROGRAM – REFERRAL FORM
OUTPATIENT MENTAL HEALTH SERVICES**

Phone: 519-257-5125

Fax: 519-257-5296

Internal Use Only

Referral Date: _____ (MM/DD/YYYY)

Intake Date/Time: _____ (MM/DD/YYYY) _____ (HH:MM)

Assigned Worker: _____

Last: _____ First: _____

D.O.B.: _____ (MM/DD/YYYY) Gender: Male Female

Address: _____ City: _____

P.C.: _____ Health Card # _____ VC: _____

Phone No: _____ Emergency Contact: _____
(Name, Relationship & Phone)

****PHYSICIAN / PSYCHIATRIST INFORMATION REQUIRED** (SEE SECTION(15))**

NOTE – INCOMPLETE FORMS WILL BE DIRECTED BACK TO SOURCE

Admission Criteria:

FAMILY PHYSICIANS: PLEASE COMPLETE INFORMATION BELOW AND PROVIDE REQUESTED ATTACHMENTS

PSYCHIATRISTS: 1. Please also complete page 2

2. Program does not provide ongoing psychiatric follow-up following discharge

1. **Provisional DSM-V Diagnosis, if available:** _____

2. **Duration of Psychiatric Symptoms:** Recently Duration < 2 years Duration 2 years or more
Past Suicidal Behaviour? If yes, please explain.

3. **Current MEDICATIONS:** DOSAGE:

4. **Physical health/conditions:**

5. **Is patient currently seeing a psychiatrist?** If yes, who? _____ Next Appt. Date: _____
If Previously, who/when? _____
(Please forward any psychiatric reports, consultations, discharge reports as applicable)

6. **Past PSYCHIATRIC Hospitalization:** No Yes If yes, please indicate hospital and approximate date

7. **Describe nature and extent of client's substance use. Is client also compulsive gambler?** No Yes
Does client recognize they have a problem? No Yes

8. **Current involvement with any other mental health/counselling services?**

9. **Any barriers to communication?** No Yes





**PHYSICIAN REFERRAL FORM
CONCURRENT DISORDER PROGRAM
OUTPATIENT MENTAL HEALTH SERVICES**
Phone: 519-257-5125 Fax: 519-257-5296

Client Name: _____

D.O.B.: _____ (MM/DD/YYYY)

PLEASE INCLUDE COPIES OF ANY PSYCHIATRIC REPORTS COMPLETED IN RECENT YEARS (if available).

10. Client's primary psychiatric diagnosis and co-morbidities (including addictions and pain disorders) (if applicable):

11. What is the goal of this referral? What is it that you are expecting to be accomplished?

12. What medications have been tried and with what results? (If not complete on previous page)

13. What type of psychotherapy has been tried? (Individual, group, self-help, etc.)

TO BE COMPLETED BY PRIMARY CARE PHYSICIANS AND/OR PSYCHIATRISTS

- 14. (a)** I am agreeable to a 1X consultation with the program psychiatrist
 I am agreeable to having the program psychiatrist see this patient for the program duration, with the understanding that treatment changes may occur

Length of time as care provider for this patient: _____

- (b) Our program does NOT provide on-going psychiatry follow up upon program completion and patient will be returned to your care. Are you agreeable to this?**
 No Yes If no, why?

Referring Doctor or NP: _____

Family Doctor: _____

Address: _____

Address: _____

Physician No.: _____

Physician No.: _____

Phone No.: _____

Phone No.: _____

Referring Doctor's Signature: _____

