

If you have any questions about the referral process, please contact Centre for Mental Health Central Intake at:

TEL 416-603-5025 | FAX 416-603-5215 | EMAIL CMHcentralintake@uhn.ca

Centre for Mental Health Referral Form

INFORMATION FOR REFERRING PROVIDERS:

- A physician or nurse practitioner referral is required for the majority of services at UHN. It is preferred that the referral comes from a primary care provider, family physician or treating psychiatrist.
- Each clinic has their own inclusion criteria. You can review catchment area information and inclusion criteria on our website: https://www.uhn.ca/MentalHealth/Clinics
- For the Rapid Access Addictions Medicine (RAAM)
 Clinic, patients do not need a referral or an appointment, and are seen on a walk-in basis. Your patient can refer to clinic website:
 (https://www.uhn.ca/MentalHealth/Clinics/Rapid Access Addiction Medicine)
 for location and walk-in hours or call 416-726-5052 for further enquiries.
- UHN's Eating Disorders program is for short-term, intensive eating disorder treatment and does not offer a stand-alone consultation/assessment service, treatment for obesity, binge eating disorder or longterm follow-up for eating disorders.
- Services are **not available** for the following:
 - Primary concern of ADHD, Autism Spectrum Disorder (ASD), or Developmental Delay
 - Individuals requiring psycholegal assessments who are referred by the court, legal counsel or other third parties.
- UHN's Centre for Mental Health services are for brief interventions and episodes of care. We do not offer long-term mental health care.

INFORMATION FOR YOUR PATIENT:

- We are not an emergency service. If your patient is too ill to wait for an assessment, please consider accessing a Psychiatric Crisis Service or Emergency Department at the nearest hospital.
- The patient is aware that the referral is being made, and the referral package includes the required PHI for review.
- Patients and referring providers can contact Centre for Mental Health Central Intake at 416-603-5025 to check the status of their referral.
- Once the referral is accepted, the patient will be contacted by a clinic to book their first appointment.
- Given UHN is a teaching hospital network, please inform your patient that they can expect to have residents or students involved in their care.
- Patients without a primary care provider will be asked to follow up with the referring provider (including walk-in clinic providers) upon completion of their consultation or episode of care.

HOW TO SUBMIT A REFERRAL:

Please fax the completed Centre for Mental Health referral form to: 416-603-5215

Please include Referral Addendum if you are referring for the following: Eating Disorders, 22q11.2 Deletion/Related Genetic Conditions, or Substance Use.

Please ensure each referral is faxed individually and that patient contact information is accurate. Outdated or inaccurate contact information may result in delays or referral decline due to inability to communicate appointment information to the patient.

To help us provide the best care possible, include relevant documents such as previous psychiatric consultations or discharge summaries, medication sheets, psychological reports, lab and test results, medical reports and physical findings.

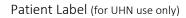
If your patient is in need of immediate help, please direct them to the nearest emergency department or call 911.



Patient Label (for UHN use only)	

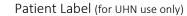
UHN CENTRE FOR MENTAL HEALTH REFERRAL FORM

Date of Referral (DD/MM/YYYY):							
☐ Please check th	is box if this patient has pr	reviously bee	n treated at a clinic with	nin UHN's Centre for Mental Hea	lth.		
PATIENT INFORMA	ATION						
Legal Name Preferred Name (if applicable					1		
First Name:	Last Name:						
Date of Birth	Sex on ID	Ger	nder Identity				
(DD/MM/YYYY):	□Female □Male □X □Un	known 🗆 🗆 W	Voman □ Man □Transgende	er Woman □Transgender Man □Oth	er □Agender		
		□В	igender □Genderfluid □No	nbinary (gender queer) \square Nonconform	ning □Pangender		
			uestioning or unsure \Box Two-	-Spirit \square Do not know \square Prefer not to	answer		
Insurance Coverag	e Information: \square OHIP \square	Other Insur	rance (please specify): _	🗆 None/Self	Pay		
HCN:	VC: F	or non-OHIP co	verages, please include copie	es of insurance documents with policy/	insurance number.		
D. C. LALL					_		
Patient Address							
Street Address:			Province:	Postal Code:			
By listing telephone nu	Impers and/or an email address	s helow the ref	erral source confirms that the	e patient consents for UHN's Centre fo	or Mental Health		
				of appointment booking and appointn			
Contact information		The telephone o	a, e. ea rer tire parpese	or appearance account and appearance	Terre decam		
		rify name & re	lationship to patient).				
	#1:						
Type: Tel f	#2:	Con	sent to voicemail message	as: \square Ves \square No			
турс тегт	τΖ.	COII.	sent to voiceman message	.s. 🗀 163 🗀 140			
Email address:							
Preferred Languag	e:	Inte	erpreter Required? 🗆 Yo	es 🗆 No			
	Are there any accommodations required for this patient to receive care? Yes: No						
•	•	•	-				
REFERRING PROVI	DER INFORMATION						
Referring Provider	Name		Referring Provider Classification:				
First Name:	Last Name:		☐ Family Physician/MD ☐ Nurse Practitioner				
			☐ Psychiatrist MD	☐ Other (please specify):			
Billing Number:							
_							
Referring Provider	Address						
Street Address:							
City:			Province:	Postal Code:			
Phone:		Fax:		Email:			
Will the referring p	provider continue to follow	v this patient	's care? ☐ Yes ☐ No ☐	□ Unknown			





CARE TEAM INFORMATION							
Primary Care Provider Name			☐ Same as Referring Provider				
First Name: Last Name:			Ŭ				
Primary Care Provider Address							
Street Address:							
City:	Province:		Postal Code:				
Phone:	Fax:	Email:					
Thorie.	Tux.	Lilian.					
Please identify the mental health provid	· · · · · · · · · · · · · · · · · · ·	• •					
☐ Psychiatrist ☐ Psychotherapy Provider/Socia							
Please provide names of the mental hea	Ilth providers involved in this patient	ent's Are the providers aware of this referral?					
care (if any):			☐ Yes ☐ No ☐ Unknown				
1 DEASON FOR REFERRAL (Disease in all	. d. D. f A. d	الم من المناطقة	a fallentina Fatina Diseaster aTNAC treatment				
Substance Use, or 22q11.2 Deletion/Relate		ing for th	e following: Eating Disorder, rTMS treatment,				
·	<u> </u>						
Please indicate the primary reason for re General Psychiatry: Anxiety Bipolar De		via/Dayaha	osis Situational Cricis/Adjustment Disorder				
Substance Use	epression 🗆 OCD 🗆 PTSD 🗀 Schizophrei	iia/PSyCiiC	sis 🗆 Situational Crisis/Adjustment disorder				
□ Jubstance O3e							
Medical Psychiatry: ☐ Acquired Brain Injury ☐	Cardiac □ Dementia □ Eating Disorder □	☐ Epilepsy	√Seizures □ HIV □ Liver □ Movement Disorders				
☐ Renal/Dialysis ☐ Rheum	atology □ Sleep Disorders □ 22q11.2 De	letion/Rel	ated Genetic Conditions				
Please indicate comorbid diagnoses (if ar							
			☐ Eating Disorder ☐ OCD ☐ Personality Disorder				
☐ Psychotic Disorder ☐ PTSD ☐ Substance U							
Please indicate any additional information	on (specific symptoms, timeframe, e	tc.):					
Please select the service(s) you're seeking	ng for your patient, if applicable:						
☐ Diagnostic Clarification ☐ Medication Consu	• , , , , ,) □ Specif	ic Treatment (e.g. rTMS):				
☐ Group Therapy (language-specific): ☐ Manda		•	, , ,				
2. PSYCHIATRIC & MEDICAL HISTORY							
Please provide a brief description of the patient's medical history and any past psychiatric history (including treatments,							
hospitalizations, etc.):	patient's medical history and any pa	ast psyci	natric history (including treatments,				
nospitalizations, etc.).							
<u> </u>							
Recent Labs/Investigations: ☐ Available in	n ConnectingOntario 🗆 Attached to Referra	al 🗌 No R	ecent Investigations				





3. MEDICATIONS (both psychiatric a	and no	n psych	niatric)				
Medication Name:	Dose/Frequency		ency	Duration:	Response (including adverse effect):		
				l			
4. SAFETY & LEGAL CONCERNS							
Risk Issue:	YES	NO	If yes,	when (DD/MM/Y	YYY):	Details (mandatory if yes):	
Suicide Attempt/Ideation							
Deliberate Self-Harm							
Violent or Aggressive Behaviour							
Active alcohol/substance use							
Please indicate if any of the followi	ng app	ies to t	his patie	ent:			
☐ Risk of falls ☐ Criminal/Legal Involvement ☐ Open WSIB Claim ☐ Concerns with ability to drive Relevant details:							
COMMENTS/ADDITIONAL INFORMA	ATION						
Completed by:							
(Print name & credentials)		 (sig	nature)	Typing constitutes	your le	gal signature. Date (DD/MM/YYYY)	
Forms completed electronically should be UHN Centre for Mental Health Central Inta Tel: 416-603-5025 Fax: 416-603-5215 E Please review instructions included. Clinic criteria available on our website: htt	ake mail: <u>CM</u>	Hcentralir	ntake@uhr				

Please include Referral Addendum if you are referring for the following: Eating Disorders, 22q11.2 Deletion/Related Genetic Conditions, or Substance Use.





UHN CENTRE FOR MENTAL HEALTH REFERRAL ADDENDUM

ADDENDUM — SERVICE-SPECIFIC INFORMATION (For select services only. Please complete all that apply)

EATING DISORDERS					
Presenting Problems:			Height:		
☐ Anorexia Nervosa			Current Weight:		
☐ Bulimia Nervosa			Weight Trajectory:		
☐ Avoidant/Restrictive Food Intake Disorder (ARI	ID)				
☐ Other (please specify:			BMI:		
Eating Disorder Behaviours	YES	NO	Frequency (#) per day	Frequency (#) per week	
Binge Eating					
Vomiting					
Laxatives					
Weight Loss Medications					
Diuretics					
Excessive Exercise					
Food Restriction			Estimated daily caloric intake	:	
Physical Examination – Attach recent bloo	od work	c and ECC	(both documents are red	quired).	
Potassium: Hemoglobin:		Notes:			
North York General Hospital)? ☐ Yes ☐ N If yes, please specify: ☐ I confirm the following: ☐ I am the patient's MRP and will be involved in receives treatment at UHN. ☐ The patient is aware that the referral is being r	ng Disor	rders Pro	gram at this time (e.g. Tril		
22q11.2 DELETION/RELATED GENETIC CONDITIONS					
Which of the following would most benef ☐ Multi-system 22q11 .2DS assessment and reco ☐ Genetic counselling ☐ Family support ☐ Psyr ☐ Community based support ☐ Other (please sp	mmenda chosocial pecify):	tions 🗆 Li	fetime medical review & clinica support Dietary and healthy	l summary	
Please note the documents attached or available for this patient: ☐ Genetic testing that confirms a 22q11.2 deletion (or other genetic condition) ☐ Cardiac history (echocardiogram, consult notes) ☐ Immune / auto-immune / hematologic issues ☐ Other relevant health issues (e.g. renal / abdominal ultrasound ☐ Intellectual functioning assessment					



F	Patient Label (for UHN use only)	

SUBSTANCE USE			
Please clarify which addiction service you are referring to:	Substance name:	Amount/Frequency:	Date of last use:
\square Individual addiction counselling \square Addiction medicine			
Check all that apply to the patient:			
Experiences withdrawal symptoms (please specify):			
☐ Mandated/Required by a court order to attend treatment to address substance use concerns (please specify):			
☐ Safely able to stop using substances for a minimum of 12 hours			
If referring to addiction medicine service, please check all that			
apply:			
☐ Alcohol Use Disorder			
☐ Alcohol Withdrawal Follow Up			
Opioid Use Disorder			
Opioid Withdrawal Follow Up			
Other (please specify):			