

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.
- Please ensure your patient is aware that the referral is being made.
- 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, rTMS treatment, Substance Use, or 22q11.2 Deletion/Related Genetic Conditions.

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.

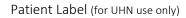
If your patient is in need of immediate help, please direct them to the nearest emergency department or call 911.



Patient Label (for UHN use only)

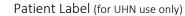
## UHN CENTRE FOR MENTAL HEALTH REFERRAL FORM

Date of Referral (DD/MM/YYYY):					Referral Priority: ☐ Routine ☐ Urgent		
☐ Please check thi	s box if this patient has pr	eviously beer	n treated at a clinic with	in UHN's	Centre for Mental He	alth.	
PATIENT INFORMA	TION						
Legal Name			Preferred Name (if applicable)				
First Name:	Last Name:						
Date of Birth	Sex on ID	Ger	nder Identity				
(DD/MM/YYYY):	□Female □Male □X □Un	known $\square$ W	′oman □ Man □Transgende	er Woman 🛭	∃Transgender Man □Oth	ıer □Agender	
		□Ві	$\square$ Bigender $\square$ Genderfluid $\square$ Nonbinary (gender queer) $\square$ Nonconforming $\square$ Pangender				
		□Q	uestioning or unsure 🗆 Two-	Spirit □Do	not know □Prefer not to	answer	
Insurance Coverage	e Information: $\square$ OHIP $\ \square$	Other Insur	ance (please specify):		🗆 None/Sel	f Pay	
HCN:	VC: F	or non-OHIP co	verages, please include copies	s of insuran	ce documents with policy,	<sup>/</sup> insurance number.	
Patient Address							
Street Address:			Daniel -		Double Code		
City:		. l l	Province:		Postal Code:		
	mbers and/or an email address hem or their alternate contact						
Contact informatio		ма тејерноне а	na/or email for the purpose of	ог арроппит	ient booking and appoint	nent detail.	
		oifu nama 0 ra	lationship to pationt).				
	<b>ate</b> (if alternate, please spec						
	:1:						
Type: Tel#	22:	Cons	sent to voicemail message.	s: ∟ Yes I	⊒ NO		
Email addrass							
Email address:	 e:	1.1.					
Are there any accommodations required for this patient to receive care?   Yes:   No						. ⊔ No	
REFERRING PROVID	DER INFORMATION						
Referring Provider	Name		Referring Provider Clas				
First Name:	Last Name:		☐ Family Physician/MD		e Practitioner		
			☐ Psychiatrist MD	☐ Other	(please specify):		
Billing Number:							
Referring Provider	Address						
Street Address:							
City:	<u></u>		Province:	<u></u>	Postal Code:		
Phone:		Fax:		Email:			
Will the referring p	rovider continue to follow	/ this patient'	s care?□Yes□No□	1 Unknow	'n		





CARE TEAM INFORMATION							
Primary Care Provider Name			☐ Same as Referring Provider				
First Name: Last Name:			-				
Primary Care Provider Address							
Street Address:							
City:	Province:		Postal Code:				
Phone:	Fax:	Email:					
Please identify the mental health provid	ers involved in this patient's care (if	any):					
☐ Psychiatrist ☐ Psychotherapy Provider/Socia	l Worker 🛘 Case Manager 🗖 Other (pleas	se specify)	:				
Please provide names of the mental hea	Ith providers involved in this patient	t's Are the providers aware of this referral?					
care (if any):			☐ Yes ☐ No ☐ Unknown				
` ''							
1 DEASON FOR REFERRAL (Bloom inch	ida Dafarral Addandum if you are refer	ing for th	e following: Eating Disorder, rTMS treatment,				
Substance Use, or 22q11.2 Deletion/Relate		ing ioi tii	e following. Eating Disorder, Frivis treatment,				
Please indicate the primary reason for re							
General Psychiatry: ☐ Anxiety ☐ Bipolar ☐ De		nia/Psvcho	sis  Situational Crisis/Adjustment Disorder				
□ Substance Use	-pr-ession	, ,					
	<del>-</del>		/Seizures ☐ HIV ☐ Liver ☐ Movement Disorders				
☐ Renal/Dialysis ☐ Rheum	atology ☐ Sleep Disorders ☐ 22q11.2 De	letion/Rel	ated Genetic Conditions				
Please indicate comorbid diagnoses (if an	nv)•						
		ression [	☐ Eating Disorder ☐ OCD ☐ Personality Disorder				
☐ Psychotic Disorder ☐ PTSD ☐ Substance U							
Please indicate any additional information (specific symptoms, timeframe, etc.):							
Please select the service(s) you're seekii	ng for your patient, if applicable:						
☐ Diagnostic Clarification ☐ Medication Consu		) □ Specif	ic Treatment (e.g. rTMS):				
☐ Group Therapy (language-specific): ☐ Mandarin ☐ Cantonese ☐ Portuguese							
2. PSYCHIATRIC & MEDICAL HISTORY							
Please provide a brief description of the patient's medical history and any past psychiatric history (including treatments,							
hospitalizations, etc.):	, , , , , ,	• •	,, , , , , , , , , , , , , , , , , , , ,				
· · · · ·							
Recent Labs/Investigations: ☐ Available in	n ConnectingOntario 🗆 Attached to Referra	al 🗆 No R	ecent Investigations				





3. MEDICATIONS (both psychiatric a	and no	n psyc	hiatric)					
Medication Name:	Dose	ose/Frequency		Duration:	Response (including		adverse effect):	
		•	•		•			
					ı			
4. SAFETY & LEGAL CONCERNS								
Risk Issue:	YES	NO	If yes,	when (DD/MM/Y	YYY):	Details (manda	atory if yes):	
Suicide Attempt/Ideation								
Deliberate Self-Harm								
Violent or Aggressive Behaviour								
Active alcohol/substance use	П							
Please indicate if any of the followi			this pation	ent:				
☐ Risk of falls ☐ Criminal/Legal In			-	n WSIB Claim	$\Box$ (	Concerns with al	aility to drive	
Chiminal Legarini	VOIVCIII	CIIC	□ Орс	II WSID ClaiiII		Concerns with at	mity to drive	
Relevant details:								
COMMENTS/ADDITIONAL INFORMA	ATION							
Completed by:								
(Print name & credentials)		(sig	gnature)	Typing constitutes	your le	gal signature.	Date (DD/MM/YYYY)	
Forms completed electronically should be UHN Centre for Mental Health Central Inta	_	nd faxed f	:0:					
Tel: 416-603-5025   Fax: 416-603-5215   E		Hcentrali	ntake@uhr	<u>1.ca</u>				
Please review instructions included.			NA	hh /p - f				
Clinic criteria available on our website: <a href="htt">htt</a>	hs:\\MMM	v.unn.ca/	ivientalHea	iui/Keierral-Listings				

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



### UHN CENTRE FOR MENTAL HEALTH REFERRAL ADDENDUM

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

EATING DISORDERS							
Presenting Problems:				Height:			
☐ Anorexia Nervosa				Current Weight:			
☐ Bulimia Nervosa				Weight Trajectory:			
$\square$ Avoidant/Restrictive Food	Intake Disorder (AF	RFID)		BMI:		<del></del>	
☐ Other (please specify:				DIVII.			
Eating Disorder Behaviou	ırs	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 – A	ttach recent blo	ood work	and ECo	G (both documents are req	uired).		
Potassium: F	Hemoglobin:		Notes:		<u></u>		
Is the patient currently really lifyes, please specify:				s elsewhere?   Yes   No			
Has a referral been made to another Eating Disorders Program at this time (e.g. Trillium Health Partners, The Ottawa Hospital, North York General Hospital)?   Yes No  If yes, please specify:							
receives treatment at UHN.  The patient is aware of and The patient and I are aware	d has agreed to this e that the program	referral.		providing ongoing health care no and-alone assessment or long-te		during, and after this patient this referral is to be considered for	
time-limited treatment services.							
*TNAC TOFATNAFNIT							
rTMS TREATMENT Please describe any prev	ious neurostimu	ılation:					
Type of Treatment (i.e. TMS, ECT, MST)	Date(s):	Duratio		escribe any benefits (with w	vhich	Location/Clinic/Hospital:	
			-,				
			-				
			-				



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:					
☐ Individual addiction counselling ☐ 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):								
	1		l					
22q11.2 DELETION/RELATED GENETIC CONDITIONS								
Which of the following would most benefit your patient, their family, and you? (Check all that apply):								
☐ Multi-system 22q11 .2DS assessment and recommendations ☐ Lifetime medical review & clinical summary								
☐ Genetic counselling ☐ Family support ☐ Psychosocial/financial support ☐ Dietary and healthy lifestyle education								
☐ Community based support ☐ Other (please specify):								
Please note the documents attached or available for this patient:								
$\square$ Genetic testing that confirms a 22q11.2 deletion (or other genetic condition	n) 🗆 Psychiatric	history (consult notes)						
☐ Cardiac history (echocardiogram, consult notes) ☐ Endocrine issues (consult notes, blood work)								
☐ Immune / auto-immune / hematologic issues		t of hearing and visual funct	ion					
☐ Other relevant health issues (e.g. renal / abdominal ultrasound	☐ Intellectual	functioning assessment						