UHN Centre for Mental Health

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 long-term 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.

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UHN CENTRE FOR MENTAL HEALTH REFERRAL FORM

Date of Referral (DD/MM/YYYY): _____	Referral Priority: ☐ Routine ☐ Urgent

☐ Please check this box if this patient has previously been treated at a clinic within UHN's Centre for Mental Health.

PATIENT INFORMATION

Legal Name
First Name: Last Name:

Preferred Name (if applicable)

Date of Birth (DD/MM/YYYY):

Sex on ID
☐Female ☐Male ☐X ☐Unknown

Gender Identity
☐Woman ☐ Man ☐Transgender Woman ☐Transgender Man ☐Other ☐Agender
☐Bigender ☐Genderfluid ☐Nonbinary (gender queer) ☐Nonconforming ☐Pangender
☐Questioning or unsure ☐Two-Spirit ☐Do not know ☐Prefer not to answer

Insurance Coverage Information: ☐ OHIP ☐ Other Insurance (please specify): _____ ☐ None/Self Pay
HCN: _____ VC: _____ *For non-OHIP coverages, please include copies of insurance documents with policy/insurance number.*

Patient Address
Street Address: _____
City: _____ Province: _____ Postal Code: _____

By listing telephone numbers and/or an email address below, the referral source confirms that the patient consents for UHN's Centre for Mental Health to communicate with them or their alternate contact via telephone and/or email for the purpose of appointment booking and appointment detail.

Contact information is for:
☐ **Patient** ☐ **Alternate** (if alternate, please specify name & relationship to patient): _____
Type: _____ Tel #1: _____ Consent to voicemail messages: ☐ Yes ☐ No
Type: _____ Tel #2: _____ Consent to voicemail messages: ☐ Yes ☐ No

Email address: _____

Preferred Language: _____ **Interpreter Required?** ☐ Yes ☐ No
Are there any accommodations required for this patient to receive care? ☐ Yes: _____ ☐ No

REFERRING PROVIDER INFORMATION

Referring Provider Name
First Name: Last Name:

Billing Number:

Referring Provider Classification:
☐ Family Physician/MD ☐ Nurse Practitioner
☐ Psychiatrist MD ☐ Other (please specify): _____

Referring Provider Address
Street Address: _____
City: _____ Province: _____ Postal Code: _____

Phone:	Fax:	Email:

Will the referring provider continue to follow this patient's care? ☐ Yes ☐ No ☐ Unknown

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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 providers involved in this patient's care (if any):

☐Psychiatrist ☐ Psychotherapy Provider/Social Worker ☐ Case Manager ☐ Other (please specify): _____

Please provide names of the mental health providers involved in this patient's care (if any):	Are the providers aware of this referral? ☐ Yes ☐ No ☐ Unknown

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

Please indicate the primary reason for referral (select one):

General Psychiatry: ☐ Anxiety ☐ Bipolar ☐ Depression ☐ OCD ☐ PTSD ☐ Schizophrenia/Psychosis ☐ Situational Crisis/Adjustment Disorder ☐ Substance Use

Medical Psychiatry: ☐ Acquired Brain Injury ☐ Cardiac ☐ Dementia ☐ Eating Disorder ☐ Epilepsy/Seizures ☐ HIV ☐ Liver ☐ Movement Disorders ☐ Renal/Dialysis ☐ Rheumatology ☐ Sleep Disorders ☐ 22q11.2 Deletion/Related Genetic Conditions

Please indicate comorbid diagnoses (if any):

☐ ADHD ☐ Anxiety ☐ Autism ☐ Bipolar ☐ Concussion/Head Injury ☐ Dementia ☐ Depression ☐ Eating Disorder ☐ OCD ☐ Personality Disorder ☐ Psychotic Disorder ☐ PTSD ☐ Substance Use ☐ Tourette/Tics ☐ Other (please specify): _____

Please indicate any additional information (specific symptoms, timeframe, etc.):

Please select the service(s) you're seeking for your patient, if applicable:

☐ Diagnostic Clarification ☐ Medication Consultation ☐ Urgent Stabilization (short term) ☐ Specific 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 ConnectingOntario ☐ Attached to Referral ☐ No Recent Investigations

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3. MEDICATIONS (both psychiatric and non psychiatric)

Medication Name:	Dose/Frequency	Duration:	Response (including adverse effect):

4. SAFETY & LEGAL CONCERNS

Risk Issue:	YES	NO	If yes, when (DD/MM/YYYY):	Details (mandatory if yes):
Suicide Attempt/Ideation	☐	☐		
Deliberate Self-Harm	☐	☐		
Violent or Aggressive Behaviour	☐	☐		
Active alcohol/substance use	☐	☐		

Please indicate if any of the following applies to this patient:

☐ Risk of falls ☐ Criminal/Legal Involvement ☐ Open WSIB Claim ☐ Concerns with ability to drive

Relevant details: _____

COMMENTS/ADDITIONAL INFORMATION

Completed by:

_____ _____ _____

(Print name & credentials) (signature) Typing constitutes your legal signature. Date (DD/MM/YYYY)

Forms completed electronically should be signed and faxed to:
UHN Centre for Mental Health Central Intake
Tel: 416-603-5025 | Fax: 416-603-5215| Email: CMHcentralintake@uhn.ca
Please review instructions included.
Clinic criteria available on our website: https://www.uhn.ca/MentalHealth/Referral-Listings

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UHN CENTRE FOR MENTAL HEALTH REFERRAL ADDENDUM

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

EATING DISORDERS

Presenting Problems:

☐ Anorexia Nervosa
☐ Bulimia Nervosa
☐ Avoidant/Restrictive Food Intake Disorder (ARFID)
☐ Other (please specify: _____)

Height: _____
Current Weight: _____
Weight Trajectory: _____
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 blood work and ECG (both documents are required).

Potassium: _____ Hemoglobin: _____ Notes: _____

Is the patient currently receiving eating disorders services elsewhere? ☐ Yes ☐ No

If yes, please specify: _____

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: _____

I confirm the following:

☐ I am the patient's MRP and will be involved in this patient's care, providing ongoing health care needs leading up to, during, and after this patient receives treatment at UHN.

☐ The patient is aware of and has agreed to this referral.

☐ The patient and I are aware that the program does not provide stand-alone assessment or long-term follow-up, and this referral is to be considered for time-limited treatment services.

rTMS TREATMENT

Please describe any previous neurostimulation:

Type of Treatment (i.e. TMS, ECT, MST)	Date(s):	Duration:	Describe any benefits (with which symptoms) and side effects:	Location/Clinic/Hospital:

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SUBSTANCE USE

Please clarify which addiction service you are referring to:
☐ 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): _____

Substance name:	Amount/Frequency:	Date of last use:

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:
☐ 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
☐ Psychiatric history (consult notes)
☐ Endocrine issues (consult notes, blood work)
☐ Assessment of hearing and visual function
☐ Intellectual functioning assessment