

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.

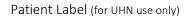
If your patient is in need of immediate help, please direct them to the nearest emergency department or call 911.



Patient Label (for UHN use only)

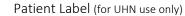
UHN CENTRE FOR MENTAL HEALTH REFERRAL FORM

Date of Referral (DD/MM/YYYY):						outine 🗆 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				Prefe	erred Name (if applicable	e)	
First Name:	Last Name:						
Date of Birth	Sex on ID	Ger	nder Identity				
(DD/MM/YYYY):	□Female □Male □X □Ur	iknown 🗆 🗆 W	/oman □ Man □Transgende	er Woman	□Transgender Man □Ot	her □Agender	
			igender □Genderfluid □No —				
			uestioning or unsure \Box Two-				
Insurance Coverag	e Information: ☐ OHIP ☐	Other Insur	ance (please specify): _		🗆 None/Se	lf Pay	
HCN:	VC:	For non-OHIP co	verages, please include copie	s of insura	nce documents with policy	/insurance number.	
D. C. LALL							
Patient Address							
					Postal Code:		
	 umbers and/or an email addres						
, , ,	them or their alternate contact	•		•			
Contact information			,				
	n ate (if alternate, please spe	cify name & re	lationship to patient):				
	#1:					-	
Type: Tel #	#2:	Con	sent to voicemail message	s. □ Yes	□ No		
1,00.			sem to voiceman message	.э. 🗀 тез	_ 110		
Email address:							
Preferred Languag	e:	Inte	erpreter Required? 🗆 Y	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	☐ Nurs	se Practitioner			
			☐ Psychiatrist MD	☐ Othe	er (please specify):		
Billing Number:							
Referring Provider	Address						
Street Address:							
City:			Province:		Postal Code:		
Phone:		Fax:		Email:			
Will the referring r	provider continue to follow	v this patient	's care? ☐ Yes ☐ No ☐	7 Unknov	wn		





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:	
Diagon i dougif , the manuful books who is			
Please identify the mental health provid	•	• •	
□ Psychiatrist □ Psychotherapy Provider/Socia			
Please provide names of the mental hea	ith providers involved in this patient	rs	Are the providers aware of this referral?
care (if any):			☐ Yes ☐ No ☐ Unknown
		ing for the	e following: Eating Disorder, rTMS treatment,
Substance Use, or 22q11.2 Deletion/Relate	<u> </u>		
Please indicate the primary reason for re			_
General Psychiatry: ☐ Anxiety ☐ Bipolar ☐ De	epression 🗆 OCD 🗆 PTSD 🗆 Schizophrer	nia/Psychos	sis 🗌 Situational Crisis/Adjustment Disorder
☐ Substance Use			
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/Rela	ated Genetic Conditions
	V.		
Please indicate comorbid diagnoses (if an		rossion [☐ Eating Disorder ☐ OCD ☐ Personality Disorder
☐ Psychotic Disorder ☐ PTSD ☐ Substance U			
Please indicate any additional information			
rease maleute any additional imormation	on (specific symptoms, timename, e		
Please select the service(s) you're seekii	ng for your natient, if annlicable:		
☐ Diagnostic Clarification ☐ Medication Consu) □ Specifi	ic Treatment (e.g. rTMS):
☐ Group Therapy (language-specific): ☐ Mand		, — -	(-0)
2. PSYCHIATRIC & MEDICAL HISTORY			
Please provide a brief description of the	patient's medical history and any pa	ast psych	iatric history (including treatments,
hospitalizations, etc.):			
S			
Recent Labs/Investigations: ☐ Available in	n ConnectingOntario ☐ Attached to Referra	al ∐ No R	ecent Investigations





3. MEDICATIONS (both psychiatric	and no	n psyc	hiatric)					
Medication Name:	Dose/Frequency		Duration:	Response (including adverse effect)		adverse effect):		
		•	•			,		
					•			
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								
Please indicate if any of the followi	ng app	lies to	this patio	ent:		<u> </u>		
. Risk of falls □ Criminal/Legal In			-	n WSIB Claim		Concerns with al	oility to drive	
, 3			'				,	
Delevent deteile								
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	signad an	d favad t						
UHN Centre for Mental Health Central Inta	-	iu iaxed l	.0.					
Tel: 416-603-5025 Fax: 416-603-5215 E	mail: <u>CM</u>	<u>Hcentrali</u>	ntake@uhr	n.ca				
Please review instructions included. Clinic criteria available on our website:								

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

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		RFID)		BMI:		
Other (please specify:		1	1	- (11)		
Eating Disorder Behavior	urs	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 EC	G (both documents are req	uired).	
Potassium: H	Hemoglobin:		Notes: _			
Is the patient currently r	eceiving eating	disorders	service	s elsewhere? Yes No		
If yes, please specify:						
Han a mafamual basis mand	- ++b F-4	ina Dian	adama Dua		: Llaaltk Dawt	none The Ottown Hoonitel
		_	ders Pro	ogram at this time (e.g. Trill	ium Health Part	ners, The Ottawa Hospital,
North York General Hosp						
If yes, please specify:						
I confirm the following:						
☐ I am the patient's MRP and	d will be involved ir	n this patie	nt's care,	providing ongoing health care no	eeds leading up to,	during, and after this patient
receives treatment at UHN.						
☐ The patient is aware of and has agreed to this referral.						
\square The patient and I are awar	e that the program	does not	provide st	and-alone assessment or long-te	erm follow-up, and	this referral is to be considered for
time-limited treatment services.						
rTMS TREATMENT						
Please describe any prev	ious neurostimi	ulation:				
Type of Treatment (i.e.	Date(s):	Duratio		escribe any benefits (with w	/hich	Location/Clinic/Hospital:
Type of Treatment (i.e. TMS, ECT, MST)	Date(s):	Duratio		escribe any benefits (with w mptoms) and side effects:	vhich	Location/Clinic/Hospital:
	Date(s):	Duratio		•	vhich	Location/Clinic/Hospital:
	Date(s):	Duratio		•	/hich	Location/Clinic/Hospital:
	Date(s):	Duratio		•	/hich	Location/Clinic/Hospital:
	Date(s):	Duratio		•	/hich	Location/Clinic/Hospital:
	Date(s):	Duratio		•	/hich	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):								
22q11.2 DELETION/RELATED GENETIC CONDITIONS								
Which of the following would most benefit your patient, their fam	nily, and you? (Check al	I 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)		ssues (consult notes, blood	-					
☐ Immune / auto-immune / hematologic issues		of hearing and visual funct	ion					
\square Other relevant health issues (e.g. renal / abdominal ultrasound	□ Intellectual	functioning assessment						