Pathstone Mental Health

Primary Care Referral Form

***Our intake process will ensure your referral will be directed to the appropriate services* FAX: 905-688-0683**

***If client is 16+, are parents aware of referral?** ☐ YES ☐ NO

Patient/Client's Personal Information

Name: Pref. Name:		Health Card Number :
Address :	City :	Postal Code
Telephone :	Cell :	Other :
DOB :	Age :	Gender :
Parent's Name :	Parent's Name :	
Resides with : (Choose)	Custody Type: N/A ☐ Joint ☐ Sole ☐	
Family Physician :	Telephone : - -	
Psychiatrist :	Telephone : - -	

Referral Information

Referred by :	Date :	Physician's Billing # :

Risks	Current	Previous	Within the last year		Current	Previous	Within the last year
Thoughts of suicide:	☐	☐	☐	Thoughts of harm to others:	☐	☐	☐
Suicide attempts:	☐	☐	☐	Engaged in harm to others:	☐	☐	☐
Thoughts of self-harm:	☐	☐	☐	Substance/alcohol misuse:	☐	☐	☐
Engaged in self-harm:	☐	☐	☐	High risk actions:	☐	☐	☐
				Police/legal involvement:	☐	☐	☐

Service(s) Requested:

☐ **Counselling/Therapy**

☐ **Psychiatric Consult (for Diagnostic Clarification and/or Medication follow-up)**

Reason for Request (Required):

Medication **List of Current Medications-Please print clearly**

Name of Medication	Dosage	Frequency
Allergies		

Consent and Agreement

I/, WE THE UNDERSIGNED AGREE TO THE EXCHANGE OF PERSONAL HEALTH INFORMATION BETWEEN AND PATHSTONE MENTAL HEALTH. I FURTHER AGREE TO THE PERSONAL HEALTH INFORMATION EXCHANGE BETWEEN PATHSONE MENTAL HEALTH AND NIAGARA HEALTH BE COLLECTED, USED, OR DISCLOSED FOR THE PURPOSE OF REFERRAL, TREATMENT PLANNING, COORDINATION AND FOLLOW UP SERVICES/SUPPORTS. I ALSO AGREE TO A SOCIAL WORKER CALLING ME FOR THE PURPOSE OF COMPLETING AN INTAKE.

_____ _____

SIGNATURE DATE

Please note that **ALL sections of this referral form are required to be completed in order to accurately process the referral. Please **ensure that consent is indicated** either by patient signing or indicating verbal consent has been given, and that the **Reason for Referral and Services Requested sections are complete.** If your patient is over 16, please ensure the form indicates whether parents are aware of referral to ensure no confidentiality of information is breached.*