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Adult Outpatient Referral Form − Mental Health and Addictions

Please **DO NOT** Fax this cover sheet with the referral

For Referring Providers

- Niagara Health Outpatient Mental Health and Addictions Program offers evidence−based assessments / treatment for adults.
- A physician / nurse practitioner referral is required for most services.
- Niagara Health **does not** offer:
  - Individual counselling
  - Grief / bereavement services
  - Anger management services
  - Assessments for complex dual diagnosis
  - Assessment, treatment and/or rehabilitation for acquired brain injury (ABI), traumatic brain injury (TBI) or concussion
  - Parenting capacity / custody access or forensic assessments
  - Assessments for the Ontario Disability Support Program (ODSP) or insurance providers / workplace
  - Assessment for legal purposes (criminal or civil)

For Your Client

- Please ensure your client is aware that the referral is being made.
- A mental health clinician will review each referral.
- Two attempts will be made to call the client. A letter will be sent to the referring provider if no contact is made.
- Some services may have a waitlist and clients will be informed of this when contact is made.
- Please provide the **While You Wait Resources** to assist the client in getting the most out of the wait time by checking out the online and self − directed resources.

How to Refer to Outpatient Mental Health and Addiction Services

- Fax the completed referral form to **905−704−4420**.
- Pages 1 and 2 must be completed in full for all referrals.
- Additional Required Information form must be completed for all Medication Clinic (Page 3), and ECT (Page 4) referrals.
- **AVOID DELAYS −** incomplete referrals delay care for your client. Ensure that all sections of the referral form are complete and all necessary information is included. All incomplete referral forms will be returned to the referring provider.
- For any enquiries, please call **905−378−4647 Extension 49613.**

Psychiatric Consultation (CAPS):

- **Inclusion Criteria:**
  - **One−time psychiatric consultation** is available with the understanding that the referring physician is responsible for the implementation of recommendations.
  - CAPS does not provide "second opinion" consults.
  - For conditions related to depressive and anxiety disorders, two medication trials within the current episode of illness is recommended before referral.
  - For conditions related to depression a PHQ−9 (completed by client) is recommended to be included with the referral.
  - For conditions related to anxiety a GAD7 (completed by client) must be included with the referral.
  - For first episode psychotic disorders, please refer to Niagara Region First Episode Psychosis Program, if appropriate

Rapid Access Addiction Medicine (RAAM)

All RAAM patients can be referred to the following walk−in services:
St. Catharines at 264 Welland Avenue − Mondays 9:00 − 11:00 a.m. / Wednesdays 1:00 − 3:00 p.m.
St. Catharines Marotta Family Hospital − Thursdays 9:00 − 11:00 a.m.
Niagara Falls Hospital − Wednesdays 9:00 − 11:00 a.m.
Welland Hospital − Fridays 9:00 − 11:00 a.m.

Contact **905−378−4647 Extension 49463** for assistance

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SECTION A: Client Information

Is client aware of referral? ☐ **Yes** ☐ **No** **Is client at risk to self / others?** ☐ **Yes** ☐ **No**

Client Name: _____ HC with Version Code: _____

Preferred Name: _____ **OR** Other Coverage (copy attached)

Address: _____ City/Town: _____

Contact Number: _____ Can a message be left at this number? ☐ Yes ☐ No

Can we use e−mail for appointment communication? ☐ Y E−mail Address: _____ ☐ No

Services may be provided virtually − E−mail Address: _____ ☐ Same as above?

Date of Birth: _____ (dd/mm/yyyy) Identify as First Nations/Indigenous? ☐ Y ☐ N

Birth Gender: ☐ Male ☐ Female ☐ Prefer not to Answer ☐ Prefer to Self−Identify _____

Preferred language? ☐ English ☐ Other: _____ Require Interpreter? ☐ Y language _____ ☐ N

Emergency Contact: Relationship _____ Contact #: _____

Indicate all that apply: ☐ Cognitive Impairment ☐ Hearing Impairment ☐ Visual Impairment ☐ Support Worker
☐ Mobility / Fall Risk ☐ Bariatric ☐ Sensory ☐ Therapy / Service Animal ☐ Other: _____

Primary Care Provider: _____ Phone Number: _____

SECTION B: (if referring to multiple programs, please number priority of services)

Program Requested:	**Reason for Referral:**	
#____ CAPS − Centralized Access to Psychiatric Services **(Physician/NP referral only)**	☐ Assessment ☐ Diagnostic Clarifications ☐ PHQ−9 attached	☐ Medication Recommendations ☐ Medication trials included ☐ GAD7 attached
#____ Seniors Mental Health **(Physician/NP referral only)**	☐ Assessment	☐ Diagnostic Clarifications ☐ Medication Recommendations
#____ Adult Group Therapy (check one diagnosis)	☐ Anxiety ☐ Bipolar ☐ Depression	☐ Emotion Dysregulation ☐ Schizophrenia ☐ Concurrent/Other:
#____ Day Hospital	☐ Complex mental health ONLY mood, anxiety or thought disorders ☐ Impairments with daily functioning	
#____ STAR − Skills Training And Recovery	**Must meet ALL the following criteria** ☐ History of trauma ☐ Severe emotion dysregulation ☐ Participate mixed gender groups	☐ Current trauma symptoms Impedes daily functioning

#____ Medication Clinic to complete this referral you must go to page 3 to input additional required information

#____ ECT Electroconvulsive Therapy to complete this referral, you must go to Page 4 for additional input

#____ CTO Community Treatment Order **(Community referrals only)**

Assess suitability:
☐ 30+ days inpatient mental health admission within past 3 years
☐ 2 lengthy inpatient mental health admissions within past 3 years
☐ previous CTO in the past

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SECTION C: PRESENTING SYMPTOMS:

Current challenges / concerns: _____

_____

_____

_____

Previous / Current Mental Health Diagnosis (**indicate mild / moderate / severe** as per PHQ−9): ☐ attached PHQ−9

_____

_____

Previous / Current Medical Diagnosis: _____

_____

_____

Medication/Supplements (both psychiatric and non−psychiatric medication) ☐ Medication List attached / additional attached

Medication	Current	Dose	Frequency	Response and Adverse Effects
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
Medication Trials: ☐ No ☐ Yes (fill out below) **OR** ☐ Client declined trials				
Medication Trials	**Current**	**Dose**	**Frequency**	**Response and Adverse Effect**
	☐ Yes ☐ No			
	☐ Yes ☐ No			

Allergies: _____

SECTION D: RISK **Please complete the following chart:**

	Within past 3 months		More than 3 months		Not Applicable	Details
	Yes	No	Yes	No		
Alcohol / Substance Use						
Physically Violent						
Suicidal Ideation						
Suicidal Attempts						
Self−Harming						
Homicidal Threat/Ideation						
Homeless / Risk Of						

Concerns regarding any immediate risk issues, please contact COAST or call 911. We do not provide crisis response services.

Primary Care Referring (print & sign): _____ Billing #: _____

Referring Number: _____ Referring Fax: _____

Referring Source Phone: _____ Referral Date: _____ (dd/mm/yyyy)

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Additional Required Information − Medication Clinic:

For any enquiries, please call Intake at 905−378−4647 Ext. 49613

Name and Current Dosage of Prescribed Medication:

☐ LAI:

☐ Clozaril® (clozapine)

New Client: ☐ CSAN #: _____

☐ attached CSAN Enrollment Form

☐ Generic Brand / Clozaril®

☐ Monitoring Portal: _____

Next dosage due date / dosage amount:	
Frequency of medication given	
Medication Start Date (dd/mm/yyyy):	
Date Medication / Injection Last Given (dd/mm/yyyy):	
How often is blood work to be completed for Clozaril®?	☐ Not Applicable
Client Aware of Medication Clinic Location?	☐ Yes ☐ No
How is client paying for Medication? (ODSP, CPP, Trillium)	☐ Attached copy of private insurance medication plan
Pharmacy where drug card being used:	
Client has transportation to Medication Clinic?	☐ Yes _____ ☐ No
Who is bringing client to appointment at clinic?	☐ Client ☐ Name/Contact #:_____
Additional Contact Person Name and Number?	☐ Yes _____ ☐ No
Referring Physician	Billing Number

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Additional Required Information − ECT − Electroconvulsive Therapy:
Clients **MUST** have had a psychiatric / mental health assessment by GP, psychiatrist or NP within past 6 months.
If not, please refer to CAPS for assessment and diagnostic clarification

Please fax all referrals to 905−704−4420. For any enquiries, please call Intake at 905−378−4647 Ext. 49613

Treatment − resistant depression	☐ Yes ☐ No
Major depressive disorder with psychotic feature	☐ Yes ☐ No
Unable to tolerate antidepressant medications	☐ Yes ☐ No
Mania non−responsive to pharmacological treatment	☐ Yes ☐ No
Acutely suicidal	☐ Yes ☐ No
Malnourished / dehydrated, rapidly deteriorating physical status	☐ Yes ☐ No
Schizophrenia − antipsychotic non−responsive	☐ Yes ☐ No
Prior ECT favourable response	☐ Yes ☐ No
Other indication for ECT	☐ Yes ☐ No

Previous ECT details (name of institution, describe the type of ECT, if bilateral / unilateral, number of treatments, response and any unusual side effects).

General Anaesthesia History: any complications with general anaesthetic? ☐ Yes ☐ No

Consent: Is the person competent to consent to treatment? ☐ Yes ☐ No
If "No" who is the substitute decision maker / contact number? _____

Lab / Diagnostic Tests must be sent with this referral: CBC, TSH, B12, Sodium, Potassium, Chloride, Ca, Mg, Phosphate, AST, ALT, GGT, ALP, Bilirubin, BUN, Creatinine, Fe, Urinalysis, EKG and any other relevant tests / procedures / consultation notes

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Internal Use Only:

Anaesthesia Consult: _____ **Physician Consult:** _____ **First ECT:** _____

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