William Osler Health System

Going Beyond

Brampton Civic Hospital
2100 Bovaird Drive East
Brampton, ON, L6R 3J7
Tel: 905-494-6709 Fax: 905-494-6710 / 6715

OUTPATIENT MENTAL HEALTH AND ADDICTIONS PROGRAM
CENTRALIZED INTAKE REFERRAL FORM (ADULT 17+)

(please complete entire form)

Incomplete / illegible referrals will be returned

Patient Name: _____ D.O.B: _____
Last name First name

Male □ **Female** □

Address: _____ Postal Code: _____

Telephone #: _____Alternate #:_____ H.C. #_____

Referring Physician's Name: _____ Physician #:_____
(Patient must be referred by a physician)

Telephone #: _____Fax #:_____

Referral discussed with patient? Yes □ No □
Can patient be contacted at home? Yes □ No □
Can message be left at home? Yes □ No □

<u>Service Request</u>:

Telephone Advice Psychiatry (TAP) □ *Please call this department for the TAP referral form*
Consultation only □
Consultation and Treatment □
Depot/Clozapine Clinic □

<u>Provisional Diagnosis</u>:

Anxiety disorder □
Mood disorder □
Personality disorder □
Adjustment disorder □
Concurrent disorder (addiction & mental health problem) □
Schizophrenia (and other psychosis) □
Dual Diagnosis (developmental delay and mental health problem) □

<u>Presenting Problem</u>:

_____
_____
_____
_____
_____
_____

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Continued on back page:

Page 2:

Risk Assessment (Suicide/Homicide): Please explain _____
_____

Current Addiction: Alcohol □ Drug □

Currently Seeing Psychiatrist: Yes □ No □

Legal Involvement: Yes □ No □ (if yes, please explain) _____
_____

Previous Psychiatric Contact: Yes □ No □ (if yes, please explain) _____
_____

Other Counselors: _____

Relevant Medical History: ***(Please include allergies)***

_____
_____
_____
_____
_____
_____

Current Medications:

_____
_____
_____
_____
_____
_____

We do not accept referrals for individuals whom you consider to be actively suicidal/homicidal. Please direct to the Emergency Department.

We do not accept referrals for legal/court purposes or for completion of medical or insurance forms.

We do not accept referrals for anger management, ADD/ADHD, couples or family counselling.

Physician Name: _____

Physician Signature: _____

Date: _____

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XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

For Clinic Staff ONLY:

Date Received: _____

Reviewed by: _____

Activity: _____
_____
_____
_____
_____

Status of Referral: _____