Anxiety Treatment & Research Clinic (ATRC) REFERRAL FORM

St. Joseph's Healthcare Hamilton, 100 West 5th Street, Hamilton, ON L8N 3K7
Tel: (905) 522-1155, ext. 33697 • Fax: (905) 521-6120 • Website: www.stjoes.ca/anxiety

- The ATRC offers services for individuals whose ***principal*** problems are due to specific anxiety disorders (e.g., panic disorder, agoraphobia, OCD, social anxiety disorder, GAD, specific phobias, and PTSD)**.** Our programs primarily include ***group-based*** cognitive behaviour therapy (CBT) and cognitive processing therapy (CPT) for specific anxiety disorders. Psychiatric consultation (diagnostic and medication) with the provision of recommendations to referring MD, and/or time limited follow-up (if appropriate) is available. Patients must be registered with a family MD to be seen by a psychiatrist. Because of the volume and complexity of the patients referred to our clinic, we cannot assume any medical or legal responsibility for their healthcare while they are awaiting a consultation.
- We are **unable** to accept referrals for legal (including pending legal charges), insurance, or Workers' Compensation purposes. We are **unable** to offer urgent assessments, case-management, supportive counseling or long-term treatment.
- If you are unsure as to the suitability of this referral or have any questions, please call Judy Odom at the above number.

If needed, we will contact the referring MD, and/or the patient for additional screening/information; the referring MD will then be advised of referral status. In all other cases, we will contact the patient with an appointment. If using EMRs, we accept referrals that contain an equivalent amount of relevant referral details using your EMR interface. All referrals need to be sent by mail/fax.

DATE OF REFERRAL: D_____M_____Y_____

Referring Physician: _____ **Specialty:**_____ **Billing #:**_____

Address: _____

Tel (**back-line** if available, to help us communicate with you faster): (_____)_____

Fax: (_____) _____ **Physician Signature:**_____

Name of Family MD (*if not the same as referring MD, please notify family MD of referral*): _____

If Family MD is part of a FHT, please check services utilized: ☐FHT Psychiatrist ☐FHT Counselor/Social Worker ☐FHT Groups

Patient Last Name:_____ **First Name:**_____ **Initial:**_____

Date of Birth: D_____M_____Y_____HIN Number: _____

Address (number & street): _____

City: _____ **Postal Code:** _____

Tel: Home (_____)_____Other (_____)_____

PURPOSE OF REFERRAL (please check all that apply):

☐ **Diagnostic Assessment** ☐ **Group Cognitive Behaviour Therapy** ☐ **Medication Consultation**

WHAT IS YOUR REFERRAL QUESTION?

_____

Please let us know what other concurrent referrals you have made in regard to the above referral/consultation question:

_____

_____

PLEASE CHECK ALL THAT APPLY TO YOUR PATIENT:

Specific to an anxiety disorder:

- ☐ Fear of panic attacks and related avoidance
- ☐ Obsessions and/or compulsions
- ☐ Social anxiety or excessive shyness
- ☐ Persistent, uncontrollable, and excessive worrying
- ☐ Persistent distress after a traumatic event
  Specify trauma: _____
- ☐ Specific fears (i.e., specific phobia)
- ☐ Hoarding
- ☐ Other:_____

Specific to all other areas of difficulty*:

- ☐ History of violence or legal problems
- ☐ Hallucinations or delusions (past or present)
- ☐ Personality Disorder
- ☐ Unipolar Depression
- ☐ Bipolar Disorder
- ☐ Learning Disability
- ☐ Current suicidal ideation
- ☐ Suicide attempt(s) (specify date, type):_____
- ☐ Current self-harm (specify):_____
- ☐ Current substance abuse/type (if active, please address prior to referral):_____
- ☐ Other:_____

*If above areas of difficulty are **primary** problems please consider if a referral elsewhere (e.g., including, but not limited to the following clinics: Mood Disorders, Community Psychiatry, Eating Disorders, Dual Diagnosis, Concurrent Disorders, Schizophrenia Outpatient, Cleghorn Early Intervention, etc.) would be more appropriate for your patient (e.g., substance abuse makes assessment/treatment for anxiety disorders difficult; thus, first consider referral to the Concurrent Disorders Program).

RELEVANT MEDICAL AND PSYCHIATRIC HISTORY:

- Medical:_____
- Psychiatric (e.g., past diagnoses):_____
- Also, please provide the following information if available (check all included with this referral):
  - ☐ Previous psychiatric consultations and in/outpatient discharge summaries
  - ☐ Cognitive/Educational/Psychological assessments
  - ☐ All clinic notes pertaining to the referral/consultation question

Past psychotropic medication trials (specify type, dose, duration, response, or attach on separate sheet):

_____

_____

All current medications (specify type, dose, duration, response, or attach on separate sheet):

_____

_____

Has this patient previously been an inpatient on a psychiatric ward? ☐Yes ☐No
If Yes, where and when, and please include discharge summary:

_____

_____

Is this patient currently under the care of a mental health professional? ☐Yes ☐No
If Yes, provide name and please include clinic notes:

_____

_____

Has this patient previously been seen at ATRC? ☐Yes ☐No
If Yes, please describe rationale for re-referral:_____

_____

Thank you for referring this patient. To minimize delays in your patient being seen, please complete this form in full.