St. Joseph's Healthcare Hamilton | Connect — Mental Health and Addiction Outpatient Programs

Provider Referral Form
Instructions and Information

Phone: (905) 522-1155, Ext.36499
Fax: (905) 389-3815
Email: connectmhap@stjoes.ca
www.stjoes.ca/connectmhap

PLEASE DO NOT FAX COVER PAGE

FOR REFERRING PROVIDERS

- **St. Joseph's Outpatient Mental Health and Addictions Program (MHAP)** offers evidence-based assessment and treatment for adults.
- A physician or nurse practitioner referral is required for most services.
- St. Joseph's **does not** offer:
  - Individual counselling
  - Grief/bereavement services
  - Parenting capacity assessments
  - Assessments for the Ontario Disability Support Program (ODSP) or insurance providers
  - Assessments for legal purposes (criminal or civil)
- For **Developmental Dual Diagnosis** referrals, patients must have a Global IQ of 70 or less prior to their 18th birthday. **Supporting documentation is required.**

FOR YOUR PATIENT

- A mental health clinician will review each referral.
- CONNECT will make two attempts to call the patient. We will call from a private/no caller ID number and leave a voicemail when consent is provided. A letter will be sent to the patient and referring provider if no contact is made.
- St. Joseph's is an academic health science and research centre, therefore patients may be invited to participate in research during their care. Participation is voluntary and not required. As a teaching hospital, learners are also involved in many aspects of patient care.
- Patients and their families can access peer support at any time by calling **Patient and Family Collaborative Services** at **905-522-1155** ext. **39559**.

HOW TO REFER TO CONNECT

- Fax the completed CONNECT referral form to **905-389-3815**
- Include any additional relevant documents such as:
  - Previous psychiatric consultations or discharge summaries
  - Neuropsychological or other psychological reports
  - Relevant lab or test results
- AVOID DELAYS – incomplete referrals delay care for your patient. Ensure that all sections of the referral form are complete and all necessary information is included.

Looking for another service? The following St. Joseph's programs have a separate referral process:

Assertive Community Treatment Team (ACTT)
Fax completed form to:
- Hamilton ACTT (ACTT1 and ACTT2) - Fax 905-528-8442
- Brant ACTT - Fax 519-758-1971

Centralized Rehabilitation Resource Clinic (CRRC)
Complete the supplemental form found on www.stjoes.ca/crrc and fax to 905-381-5612.

CONNECT does not offer crisis services.
If your patient requires immediate care, please direct them to the nearest emergency department or call 911.

Hamilton COAST	Haldimand Norfolk CAST	Niagara COAST	Brant St. Leonard's	Halton COAST
(905-972-8338) Barrett Centre (1-844-777-3571)	1-866-487-2278	1-866-550-5205 x. 1	519-759-7188 or 1-866-811-7188	1-877-825-9011

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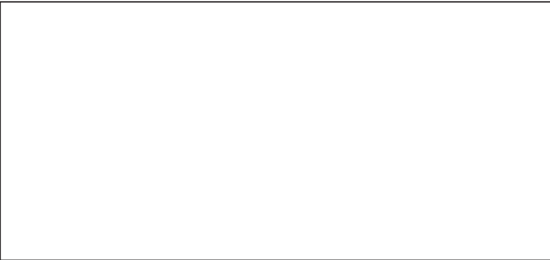

Outpatient Referral Form for Providers

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Client/Patient Information

Health Card Number: ____________________ VC: ________

* Last Name: ____________ * Legal Name: ____________ Preferred Name: ____________ Date of Birth: (yyyy/mm/dd) ____________

Address: ____________ Unit: ________ City: ____________ Postal Code: ________

*Primary Contact Phone: ____________ ☐ Mobile ☐ Landline Can a message be left at this number? ☐ No ☐ Yes

Can we use text for communication? ☐ No ☐ Yes If yes, number to text: ____________

Can we use email for communication? ☐ No ☐ Yes If yes, email address: ____________

Alternate Contact Information: ____________ Consent to contact? ☐ No ☐ Yes

Preferred Language: ☐ English ☐ Other ____________ Is an interpreter required? ☐ No ☐ Yes

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Prefer not to answer ☐ Prefer to self-identify: ____________

Community Treatment Order? ☐ No ☐ Yes (If **Yes**, include CPT & CTO)

Capable to make treatment decisions? ☐ No ☐ Yes (If **No**, include Form 33)

Substitute Decision Maker (SDM): ☐ No ☐ Yes (If **Yes**, include Form 33)

SDM Name: ____________ Emergency Contact Name: ____________

Relationship: ____________ Phone: ____________ Relationship: ____________ Phone: ____________

Other Considerations: ☐ Cognitive Impairment ☐ Hearing Impairment ☐ Visual Impairment ☐ Mobility/Fall Risk

☐ Sensory ☐ Unable to attend clinic ☐ Other: ____________

* Patient is aware of this referral and has consented to their health information being collected from various sources to make decisions regarding care. ☐ No ☐ Yes

Referral Source Information

* Provider Referring: ____________ Facility: ____________ Specialty: ____________ Billing #: ____________

Contact Person: ____________ * Phone: ____________ Backline: ____________ Fax: ____________

As the referring provider, are you willing to implement care recommendations which may result from assessment/ treatment at St. Joseph's? ☐ No ☐ Yes

Does client have a family physician? ☐ No ☐ Yes Name of family physician: ____________

Is family physician part of FHT? ☐ No ☐ Yes If yes, have internal services been accessed? ☐ No ☐ Yes (Please attach records)

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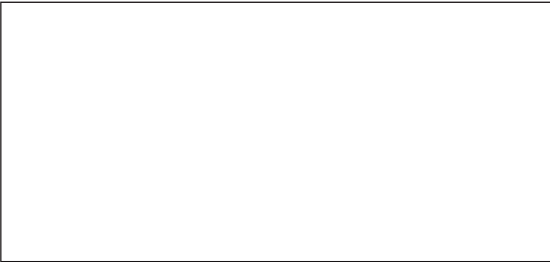

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Client/Patient Name: ______________________________

Reason for Referral

Select reason(s) for referral: ☐ Diagnostic clarification ☐ Medication consultation ☐ Evidence-based group therapy

☐ Other (please specify): ______________________________

If requesting pregnancy or post-partum support, please indicate **due date** or **delivery date**: ______________

*** Current Symptoms (Please provide a detailed description of clinical symptoms and list in priority sequence. A Symptoms Quick Reference Guide is located on page 5):**

How long has this been a concern? ☐ Less than one month ☐ 1-6 months ☐ More than 6 months

Currently receiving treatment for this concern? ☐ No ☐ Yes

If yes, Provider name, discipline and type of treatment:

Past/Present Psychiatric Diagnoses - (Please attach relevant consult notes and/or screening tools)

	Past	Present		Past	Present
Bipolar Disorder	☐	☐	Anxiety Disorder	☐	☐
Schizophrenia/Schizoaffective	☐	☐	Depression	☐	☐
Eating Disorder	☐	☐	Psychosis (Hallucinations/Delusions)	☐	☐
Personality Disorder ______________	☐	☐	Neurocognitive Disorder	☐	☐
Post Traumatic Disorder	☐	☐	Other: ______________	☐	☐

Treatment History - (Please attach assessments, discharge summaries, progress notes from other agencies, hospitals or therapies)

Hospital admission(s) for: mental health concerns: ☐ No ☐ Yes addiction concerns: ☐ No ☐ Yes

ER visit(s) for: mental health concerns: ☐ No ☐ Yes addiction concerns: ☐ No ☐ Yes

Involvement with other agencies and/or therapy? ☐ No ☐ Yes

Please provide details of when, where and outcome of treatment history. Information is necessary to complete intake process.

Medical History - (Please attach relevant CURRENT and PAST medical information, i.e. respiratory, cardiac, metabolic)

Please Describe:

Indicate all that apply: ☐ Acquired Brain Injury ☐ Developmental Disability (with IQ less than 70) ☐ Neurological Disorder

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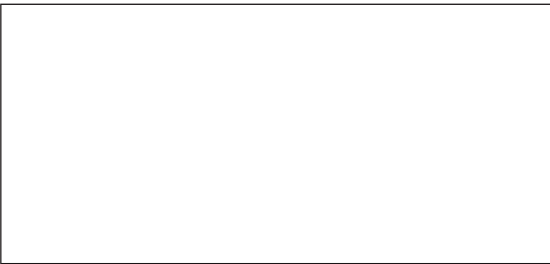

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Medication/Supplements: PSYCHIATRIC and NON-PSYCHIATRIC medications including opiate replacement therapies.

Medication	Dose/Frequency	Current	Past	Start Date	Response/Adverse Effects
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		

Substance Use

Uses alcohol or drugs weekly or more often	☐ No	☐ Yes
Spends a lot of time getting, using or recovering from the effects of alcohol/drugs	☐ No	☐ Yes
Continues to use alcohol or drugs despite negative impact	☐ No	☐ Yes
Experiences withdrawal symptoms	☐ No	☐ Yes

Substance: ______________ Amount Used: ______________ Frequency: ______________

Substance: ______________ Amount Used: ______________ Frequency: ______________

Safety Concerns (please check all that apply). If safety concerns are present, **details are REQUIRED**.

Risk	Within past 3 Months	More than 3 Months Ago	Details
Suicide Attempt	☐	☐	
Suicide Ideation	☐	☐	
Deliberate Self-harm	☐	☐	
Homicidal Threats/Ideation	☐	☐	
Physically Violent/Aggressive Behaviour	☐	☐	
Legal Involvement	☐	☐	
Homelessness/Risk of	☐	☐	
Lives Alone	☐	☐	
Other:			

Signature:

Referral Source Signature ______________________ Date Signed (yyyy/mm/dd) ______________

If referring to the Outpatient Eating Disorders Program, please complete page 4.

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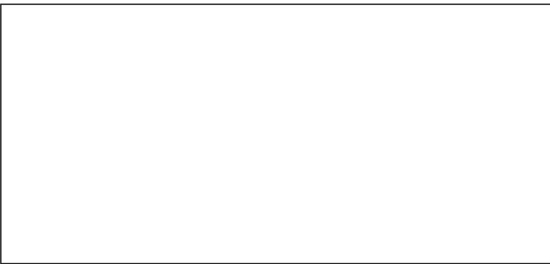

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Eating Disorders Clinic Referrals: Please complete the following sections and submit with the required investigations.

Please note the SJHH Eating Disorders Clinic is an outpatient clinic and does not have day hospital or inpatient treatment, and does not offer meal supervision. Clients must have a BMI over 16; additional considerations include medical stability, symptom severity, and psychiatric comorbidity.

Current Investigations: Mandatory - Please attach results from within the last three months.

☐ ECG	☐ Calcium	☐ Glucose	☐ TSH	☐ Alkaline Phosphatase
☐ CBC & Diff	☐ Magnesium	☐ Urea	☐ ALT	☐ Vitamin B12
☐ Electrolytes	☐ Phosphate	☐ Creatinine	☐ GGT	☐ Ferritin

☐ If Binge Eating is the **only** reported symptom, please **also** complete Fasting Lipids

Current Symptoms: Please check all that apply and include frequency. This information is necessary to determine appropriate treatment.

Symptom	No	Yes	Details/Frequency	Symptom	No	Yes	Details/Frequency
Restriction and/or Fasting	☐	☐		Diet Pills	☐	☐	
Binge Eating	☐	☐		Insulin Restriction	☐	☐	
Vomiting	☐	☐		Diuretics	☐	☐	
Laxatives	☐	☐		Extreme distress with weight and shape	☐	☐	
Extreme Exercise	☐	☐		Other: ____________	☐	☐	

Current Physical Status: Please complete in full as this information is necessary to determine appropriate treatment.

Height (cm): ____________ Weight (kg): ____________ BMI: ____________

Weight Loss: ☐No ☐Yes Weight Gain: ☐No ☐Yes Please indicate change: ________ kg over ____________ (time period)

Has this patient ever received treatment for his/her eating disorder? ☐No ☐Yes

If yes, where and when: ____

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Symptoms Quick Reference Guide

How to use: This tool is designed to help you quickly identify and communicate some of the most common mental health symptoms. It is not designed to diagnose a mental health condition.

Anxiety

- Panic attacks
- Excessive worrying
- Obsessions/Compulsions
- Restlessness
- Avoidance of anxiety-provoking stimuli
- Fear of judgement
- Physical symptoms of anxiety (e.g., sweating, heart palpitations, muscle tension)

Low Mood

- Depressed mood
- Loss of interest or pleasure in activities that used to be enjoyable
- Weight loss or gain
- Difficulty sleeping or sleeping too much
- Apathy or agitation
- Loss of energy
- Feelings of worthlessness and guilt
- Inability to concentrate

Pre-Menstrual

- Symptoms begin 1 week before menses, improve with onset of menses, and are minimal or absent following menses
- Mood swings
- Irritability or anger
- Depressed mood
- Anxiety, tension, feeling keyed up
- Feeling overwhelmed
- Physical symptoms (e.g., fatigue, breast tenderness, bloating, joint pain)

Trauma

- Distressing memories of the traumatic event(s)
- Distressing dreams about the traumatic event (s)
- Dissociative reactions (e.g., flashbacks)
- Avoidance of reminders of the traumatic event(s)
- Hypervigilance
- Exaggerated startle reflex
- Irritability
- Difficulty with sleep

Mania/Hypomania

- Symptoms persist for 4 days or more
- Exaggerated self-esteem or feelings of grandeur
- Irritable mood
- Decreased need for sleep
- More talkative than usual
- Racing thoughts
- Excessive energy for activities
- Engaging in high-risk behaviour

Psychosis

- Delusions
- Hallucinations
- Disorganized speech, thoughts, or behaviour
- Restricted emotional and facial expression
- Restricted speech and verbal fluency
- Difficulty with generating ideas or thoughts
- Reduced ability to begin tasks
- Reduced socialization and motivation

Emotional Dysregulation

- Strong emotional reactivity
- Mood swings
- Outbursts of anger
- Interpersonal relationships characterized by frequent arguments and break-ups
- Impulsivity
- Self-harm (e.g., cutting, burning or hitting self)

Additional Cognitive and Developmental Considerations

Cognition

- Difficulty with memory
- Difficulty with sustained attention
- Difficulty with wayfinding
- Difficulty with planning and organizing
- Difficulty with complex decision-making
- Wandering

Communication

- Use of alternative communication methods (non-verbal)
- Difficulty with naming and word-finding
- Difficulty with verbal comprehension
- Frequent repetition
- Physically responsive behaviours