

## PLEASE DO NOT FAX COVER PAGE

The Mental Health and Addiction Program at St. Joseph's Healthcare Hamilton specializes in the assessment and treatment of mental illness and addiction. We offer evidence-based services in anxiety disorders, mood disorders, schizophrenia and psychotic disorders, neurocognitive disorders, eating disorders, borderline personality disorder and emotion regulation difficulties, substance use disorders, mood difficulties related to the reproductive cycle, and dual diagnosis (combined mental health concerns and intellectual disabilities). The services are primarily offered for transition aged youth (17-25), adults and seniors.

**Questions about the referral process? Please call: 905-522-1155, x. 36499, or Email: [connectmhap@stjoes.ca](mailto:connectmhap@stjoes.ca)**

**In order to help us provide the best care, please include the following (if possible):**

- Relevant lab and test results
- Previous psychiatric consultations or discharge summaries
- List of medications (past and present medications, please attach pharmacy medication list)
- Physical findings
- Psychological/psychiatric reports

**Please note for the following services:**

- For the **Assertive Community Treatment Team (ACTT)**, please **fax** completed form to
  - Hamilton ACTT (ACTT1 and ACTT2) - Fax 905-528-8442
  - Brant ACTT - Fax 519-758-1971
  - Haldimand Norfolk ACTT - Fax 519-426-0971
- For **Centralized Rehabilitation Resource Clinic (CRRC)** please **also** complete and submit the supplemental form found on [www.stjoes.ca/crrc](http://www.stjoes.ca/crrc) and **fax** to 905-381-5612.
- For **Dual Diagnosis** referrals, patient must have a Global IQ of 70 or less prior to their 18<sup>th</sup> birthday. (Please **also** attach the neuropsychological testing report if available).
- For **Eating Disorder** referrals, please **also** complete the Eating Disorders Referrals Section of this form.

**Other Information:**

**Patient and Family Collaborative Support Services:** Offers peer support for individuals and family members of individuals with lived experience of a mental health or addiction issue. Please contact 905-522-1155 ext. 39559. Self-referrals are welcome.

**Research Participation:** Eligible patients may be contacted by St. Joe's researchers to gauge their interest in research participation. The choice to participate in research or not will have no effect on patient care. Patients may withdraw from research contact at any time by informing their care team at St. Joe's.

***There may be a wait for service.***

***If your patient is in crisis and is requiring immediate help, please contact your local crisis service or direct them to your nearest emergency department.***

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

# Outpatient Referral Form for Providers

Phone: (905) 522-1155 Ext. 36499 Fax: (905) 389-3815 Email: connectmhpa@stjoes.ca



Client/Patient Information	Referral Source Information
<p>* Last Name: _____ * Legal Name: _____</p> <p>Preferred Name: _____ Date of Birth: (yyyy/mm/dd) _____</p> <p>Health Card Number: _____ VC: _____</p> <p>Address: _____ Unit: _____</p> <p>City: _____ Postal Code: _____</p> <p>Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> Prefer to self-identify: _____</p> <p>* Primary Contact Phone: _____ <input type="checkbox"/> Mobile <input type="checkbox"/> Landline</p> <p>Can a message be left at this number? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Can we use text for communication? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, number to text: _____</p> <p>Can we use email for communication? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, email address: _____</p> <p>Alternate Contact Information: _____ Consent to contact? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Community Treatment Order? <input type="checkbox"/> No <input type="checkbox"/> Yes (If <b>Yes</b>, include CPT &amp; CTO)</p> <p>Capable to make treatment decisions? <input type="checkbox"/> No <input type="checkbox"/> Yes (If <b>No</b>, include Form 33)</p> <p>Substitute Decision Maker (SDM): <input type="checkbox"/> No <input type="checkbox"/> Yes (If <b>Yes</b>, include Form 33)</p> <p>SDM Name: _____</p> <p>Relationship: _____ Phone: _____</p> <p>Emergency Contact Name: _____</p> <p>Relationship: _____ Phone: _____</p>	<p>* Provider Referring: _____</p> <p>Facility: _____</p> <p>Specialty: _____ Billing #: _____</p> <p>Contact Person: _____</p> <p>* Phone: _____ Backline: _____</p> <p>Fax: _____</p> <p>Does client have a family physician? <input type="checkbox"/> No <input type="checkbox"/> Yes Name of family physician: _____</p> <p>Is family physician part of FHT? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, have internal services been accessed? <input type="checkbox"/> No <input type="checkbox"/> Yes (Please attach records)</p>
<b>Consent</b>	
<p>* Patient is aware of this referral and has consented to their health information being collected from various sources to make decisions regarding care. <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	
<b>Special Needs</b>	
<p>Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Other _____</p> <p>Is an interpreter required? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Hearing Impairment <input type="checkbox"/> Sight Impairment <input type="checkbox"/> Mobility/Fall Risk <input type="checkbox"/> Sensory (smell/light) <input type="checkbox"/> Unable to attend clinic <input type="checkbox"/> Other: _____</p>	

<b>Presenting Concerns/Referral Goal</b> (i.e. diagnostic clarification, medication review, 2 <sup>nd</sup> opinion, treatment)	
<p>* Reason for Referral: <input type="checkbox"/> New Request <input type="checkbox"/> Re-referral</p>	<p>* Indicate Urgency: <input type="checkbox"/> Urgent (&lt; 2 weeks) <input type="checkbox"/> Non-urgent</p>
<p>* Please describe presenting problems, current symptoms, and reason for urgency:</p> <div style="border: 1px solid black; height: 60px; margin-top: 5px;"></div>	
<p>How long has this been a concern? <input type="checkbox"/> Less than one month <input type="checkbox"/> 1-6 months <input type="checkbox"/> More than 6 months</p> <p>Currently receiving treatment for this concern? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If yes, Provider name, discipline and type of treatment:</p> <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>	

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Client/Patient Name: \_\_\_\_\_

## Past/Present Psychiatric Diagnoses

	Past	Present		Past	Present
Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia/Schizoaffective	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Psychosis (Hallucinations/Delusions)	<input type="checkbox"/>	<input type="checkbox"/>
Personality Disorder _____	<input type="checkbox"/>	<input type="checkbox"/>	Neurocognitive Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Post Traumatic Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

## 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  Neurological Disorder  Pregnant/Post-partum Due Date: \_\_\_\_\_

## Substance Use

Use alcohol or drugs weekly or more often?  No  Yes

Spend a lot of time either getting, using or recovering from the effects of alcohol/drugs?  No  Yes

Continue to use alcohol or drugs even though it's causing problems?  No  Yes

Experience withdrawal problems or use substances to stop being sick?  No  Yes

Substance: \_\_\_\_\_ Amount Used: \_\_\_\_\_ Frequency: \_\_\_\_\_

Substance: \_\_\_\_\_ Amount Used: \_\_\_\_\_ Frequency: \_\_\_\_\_

Substance: \_\_\_\_\_ Amount Used: \_\_\_\_\_ Frequency: \_\_\_\_\_

## Risk Issues (Please check all that apply)

Risk Issue	Yes	No	If Yes, when?	Details
Suicide Attempt	<input type="checkbox"/>	<input type="checkbox"/>		
Suicide Ideation	<input type="checkbox"/>	<input type="checkbox"/>		
Deliberate Self-harm	<input type="checkbox"/>	<input type="checkbox"/>		
Homicidal Threats/Ideation	<input type="checkbox"/>	<input type="checkbox"/>		
Violent/Aggressive Behaviour	<input type="checkbox"/>	<input type="checkbox"/>		
Legal Involvement	<input type="checkbox"/>	<input type="checkbox"/>		
Homelessness/Risk of	<input type="checkbox"/>	<input type="checkbox"/>		
Lives Alone	<input type="checkbox"/>	<input type="checkbox"/>		
Other:				

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Client/Patient Name: \_\_\_\_\_

**Medication/Supplements:** (PSYCHIATRIC and NON-PSYCHIATRIC medications including opiate replacement therapies. Please attach additional information if required.)

Medication	Dose/Frequency	Current	Past	Start Date	Response/Adverse Effects
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		

**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. Referral is for consultation/recommendations. Treatment will be offered if appropriate. Considerations include medical stability, symptom severity, psychiatric comorbidity. Clients must have a BMI over 16.

**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: \_\_\_\_\_

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

Symptom	Yes	No	Details/Frequency	Symptom	Yes	No	Details/Frequency
Restriction and/or Fasting	<input type="checkbox"/>	<input type="checkbox"/>		Diet Pills	<input type="checkbox"/>	<input type="checkbox"/>	
Binge Eating	<input type="checkbox"/>	<input type="checkbox"/>		Insulin Restriction	<input type="checkbox"/>	<input type="checkbox"/>	
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>		Diuretics	<input type="checkbox"/>	<input type="checkbox"/>	
Laxatives	<input type="checkbox"/>	<input type="checkbox"/>		Extreme distress with weight and shape	<input type="checkbox"/>	<input type="checkbox"/>	
Extreme Exercise	<input type="checkbox"/>	<input type="checkbox"/>		Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	

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

<input type="checkbox"/> ECG	<input type="checkbox"/> Calcium	<input type="checkbox"/> Glucose	<input type="checkbox"/> TSH	<input type="checkbox"/> Alkaline Phosphatase
<input type="checkbox"/> CBC & Diff	<input type="checkbox"/> Magnesium	<input type="checkbox"/> Urea	<input type="checkbox"/> ALT	<input type="checkbox"/> Vitamin B12
<input type="checkbox"/> Electrolytes	<input type="checkbox"/> Phosphate	<input type="checkbox"/> Creatinine	<input type="checkbox"/> GGT	<input type="checkbox"/> Ferritin

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

If your patient is in crisis and requiring immediate help, please contact your local crisis service or direct them to your nearest emergency department. In Hamilton, contact COAST (905-972-8338) or Barrett Centre (Toll Free 1-844-777-3571), in Haldimand Norfolk contact CAST (1-866-487-2278), in Niagara contact COAST Niagara (1-866-550-5205, ext. 1), in Brant contact Integrated Crisis Services; St. Leonard's (519-759-7188 or 1-866-811-7188), and in Halton contact COAST Halton (1-877-825-9011).

\_\_\_\_\_  
Referral Source Signature

\_\_\_\_\_  
Date Signed (yyyy/mm/dd)