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

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

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 and fax to 905-381-5612.
- For **Dual Diagnosis** referrals, patient must have a Global IQ of 70 or less prior to their 18th birthday. (Please **also** attach the neuropsychological testing report if available).
- For **Eating Disorder** referrals, please **also** complete and submit the supplemental eating disorders referral 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

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Client/Patient Information

* Last Name: ____________ * Legal Name: ____________

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

Health Card Number: ____________ VC: ____________

Address: ____________ Unit: ____________

City: ____________ Postal Code: ____________

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Prefer not to answer

☐ Prefer to self-identify: ____________

*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: ____________

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: ____________

Relationship: ____________ Phone: ____________

Emergency Contact Name: ____________

Relationship: ____________ Phone: ____________

Referral Source Information

* Provider Referring: ____________

Facility: ____________

Specialty: ____________ Billing #: ____________

Contact Person: ____________

* Phone: ____________ Backline: ____________

Fax: ____________

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 (Describe in treatment history)

Consent

* 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

Special Needs

Preferred Language: ☐ English

☐ Other ____________

Is an interpreter required? ☐ No ☐ Yes

☐ Cognitive Impairment ☐ Hearing Impairment

☐ Sight Impairment ☐ Mobility/Fall Risk

☐ Sensory (smell/light) ☐ Unable to attend clinic

☐ Other: ____________

Presenting Concerns/Referral Goal *(i.e. diagnostic clarification, medication review, 2nd opinion, treatment)*

* Reason for Referral: ☐ NewRequest ☐ Re-referral * Indicate Urgency: ☐ Urgent (< 2 weeks) ☐ Non-urgent

* Please Describe:

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:

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Past/Present Psychiatric Diagnoses

	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

Where and when?

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

Where and when?

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

Where and when?

Outcome?

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 Disabililty ☐ Neurological Disorder ☐ Pregnant

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

Risk Issues *(Please check all that apply)*

Risk Issue	Yes	No	If Yes, when?	Details
Suicide Attempt/Ideation	☐	☐		
Deliberate Self-harm	☐	☐		
Homicidal Threats/Ideation	☐	☐		
Violent/Aggressive Behaviour	☐	☐		
Legal Involvement	☐	☐		
Homelessness/Risk of	☐	☐		
Lives Alone	☐	☐		
Other: ____________				

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Medication/Supplements (PSYCHIATRIC and NON_PSYCHIATRIC medications including opiate replacement therapies. Please attach additional information if required. Use the "+" button to add more medications and the "-" button to remove medications)					
Medication	Dose/Frequency	Current	Past	Start Date	Response/Adverse Effects
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		

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)