St. Joseph's Healthcare Mood Disorders Program

Please Read Before Completing:

- Our primary mandate is to provide expert consultation for patients with diagnosed or suspected mood disorders. Typical consultation requests are for diagnostic clarification, treatment recommendations, or for both.
- To ensure accessibility and efficient use of psychiatric resources, the service emphasizes expert consultation with implementation of recommendations in the community. Consultants will provide diagnostic assessment and specific treatment recommendations. Thereafter, consultants may be contacted by phone or patients referred for re-consultation.
- Legal charges pending are exclusionary criteria.
- Referrals for patients with active substance abuse may be forwarded to the appropriate service for consult.
- In order for this referral to be processed, the referring physician must sign and provide their billing number. Referrals with no family physician will be returned.
- Please note that because of the volume and complexity of patients referred to our clinic, we cannot assume any medical or legal responsibility for their healthcare while they are waiting for consultation.

Last Name: _____ First Name:_____Initial:____

Address:_____ City:_____Postal Code:_____

Telephone: (H)_____ (C)_____ (W)_____

OHIP Number: _____ V.C.____ Date of Birth _____ Age:_____
(D/M/Y)

Gender: ❑ Male ❑ Female ❑ Trans Marital Status: _____ Patient employed ❑Yes ❑No

Family Physician:_____ (must be completed)

Referring Physician: _____Affiliated with Hamilton FHT ❑Yes ❑No

Address:_____Telephone:_____Fax:_____

Physician's Signature:_____ **Billing Number:**_____

Request For:

❑Diagnostic Clarification
❑Treatment Recommendations
❑Diagnostic Clarification & Treatment Recommendations
❑Other:_____

❑ Cognitive Behavioural Therapy
❑ Electroconvulsive Therapy (ECT)
❑ Repetitive Transcranial Magnetic Stimulation (rTMS)

Current Problem (check all that apply)

Mood Disorder:
- ❑ Depression
- ❑ Bipolar Disorder

Anxiety Disorder:
- ❑ Social Phobia
- ❑ Panic Disorder, with or without agoraphobia
- ❑ Obsessive Compulsive Disorder
- ❑ Generalized Anxiety Disorder
- ❑ Other Anxiety Disorder

Other:
- ❑ Hallucinations/ delusions (past/ present)
- ❑ Suicide Attempt(s) when?_____
- ❑ Current Suicidal Ideation
- ❑ Substance Use (type, frequency, duration)

_____

_____
- ❑ Eating Disorder
- ❑ Personality Disorder
- ❑Current or past legal issues
- ❑ History of violence
- ❑ Other:_____

Which of these is the most disabling problem currently?_____

Reason for referral (attach report if available): _____

_____

_____

_____

Relevant Medical History/ Family History (attach copies of most recent laboratory tests/ investigations):

_____

_____

Current Medications	Past Medications
_____	_____
_____	_____
_____	_____

Is the patient currently in treatment with a mental health professional? ❑ yes ❑ no

Have they been an inpatient/ had relevant mental health assessments? ❑ yes ❑ no
(please attach discharge summaries, neuropsychological testing, past consult notes)

Please fax completed form to: (905) 381-5616

St. Joseph's Healthcare, 100 West 5th Box 585, Hamilton, ON L8N 3K7