Eastern Health

Mental Health and Addictions Program

Referral Form

INCOMPLETE FORMS WILL BE RETURNED

CL1190 0016 07 2012

☐ **URGENT**

Name:

HCN:

Expiry Date:

Date of Birth:

Allergies: ☐ **No Known**

Client Information:

Mailing Address: _____

Primary Telephone: _____ Other Telephone: _____

Can message be left? ☐ *Yes* ☐ *No* *Can message be left?* ☐ *Yes* ☐ *No*

Contact Information for Next of Kin/Guardian? Relationship: _____

Any accommodations required? ☐ Yes ☐ No If so, what type: _____

Referring Source *(name, agency, address ,telephone):*

If not referring source, Primary Care Physician *(name, address,* tele*phone)*

Referral Reason (pick one of following):

☐ Assessment ☐ Counselling ☐ Diagnostic Clarification ☐ Medication Review ☐ Treatment Recommendations

Presenting Concern (*symptoms, duration, severity and contributing factors*):

If urgent, reason: _____

Previous psychiatric consultation: ☐ Yes *(attach reports if available)* ☐ No ☐ Unknown

Other services client connected with or referred to:

Medication and Dosage *(or attach list):*

Medical Conditions:

Substance use: ☐ Current ☐ Past ☐ None

Describe: _____

Suicidal Ideation: ☐ Active ☐ Passive ☐ None

Current Plan: ☐ Yes *(refer to ER)* ☐ No

Attempts: ☐ Multiple ☐ One ☐ None

Lethality: ☐ High ☐ Moderate ☐ Low

Date of last attempt: _____

Self-Harm: ☐ Current ☐ Past ☐ None

Describe: _____

Aggression (*verbal or physical*): ☐ Current ☐ Past ☐ None

Describe: _____

Name:_____ Signature:_____ Date:DD/MONTH/YYYY

The personal information is being collected under the authority of Sections 29, 30 and 31 of the Personal Health Information Act and will be used for the purpose of planning your care. If you have questions concerning the collection, use, and disclosure of this information, please contact the Mental Health and AddictionsProgram. If you have questions relating to Privacy and Access, please contact 777-8025.