Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

ADULT REFERRAL – INFORMATION AND INSTRUCTIONS

STEP 1 – BEFORE COMPLETING THE REFERRAL FORM

Go to **www.camh.net** for detailed information on each program.

physician referral is required by the following programs and services

- CATS Program / General Psychiatry
- Memory Clinic, Geriatric Mental Health Program
- Mood and Anxiety Program
- Sexual Behaviours Clinic, Law and Mental Health Program
- Women's Mental Health Program
- Telepsychiatry – Northern Psychiatric Outreach Program (NPOP-C)

for all other CAMH programs, physician referral is not required

For Addictions Program Services **do not complete this form**. Client/Patient **must call** 416-535-8501 x 6616.

For inquiries with respect to private assessments (independent medical examinations), contact must be made directly with the clinician involved.

This is not a crisis or emergency referral service. For emergencies you may call TeleHealth: 1-866-797-0000 and TTY is 1-800-387-5559; call 911; or proceed to your nearest Emergency Room.

STEP 2 – COMPLETING THE REFERRAL FORM

- Include **all known information** relevant to this referral.
- Use space available on the last page to provide additional or clarifying information.
- Include any relevant **lab results**, especially drug levels **(e.g. 12 hour trough for mood stabilizers), medical reports**, **medication sheet**, **physical lab findings**, **psychological reports**, and copies of **previous psychiatric consultations or discharge summaries**, along with a signed **consent for disclosure of personal health information**.

STEP 3 – AFTER COMPLETING THE REFERRAL FORM – FAX TO:

Fax # s for CAMH programs and services

Centralized Assessment Triage and Support (CATS) Ambulatory Service **FAX:** 416-979-6815 Gender Identity Clinic **FAX:** 416-583-1360	**Mood and Anxiety Program** Outpatient **FAX:** 416-260-4208 ECT and rTMS consultation **FAX:** 416-583-1358
Dual Diagnosis Program (Intellectual disability plus mental health issues) **FAX:** 416-504-1272 Peel **FAX:** 905-568-4159	**Schizophrenia Program** Schizophrenia Triage, Assessment and Research Service (STARS) **FAX:** 416-260-4197
Geriatric Mental Health Program **FAX:** 416-583-1296	**Women's Mental Health Program** **FAX:** 416-979-4975
Law and Mental Health Program Sexual Behaviours Clinic **FAX:** 416-260-4187	**Telepsychiatry – Northern Psychiatric Outreach Program (NPOP-C) – FAX:** 416-260-4186

Not sure where to send the referral?
Contact **CATS**:
Tel: 416-979-6878 **Fax**: 416-979-6815

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for CAMH use:
Client/Patient ID Label

ADULT REFERRAL

Date of Referral:_____
(dd/mm/yyyy)

Use last page to provide additional information

Client/Patient Information

Legal Name:_____
(last name, first name)

Preferred Name
(if applicable):_____

Date of Birth:_____ Age:_____
(dd/mm/yyyy)

Sex/Gender: ☐ Female ☐ Male ☐ Intersex
☐ Transgender ☐ Transsexual

Telephone number(s) (specify home, office, cell, etc.)
Tel:_____

Tel:_____

Can confidential message be left on client/patient voicemail? ☐ Yes ☐ No

Can confidential message be left with family? ☐ Yes ☐ No

Address:_____

_____

Can appointment letter be sent to this address? ☐ Yes ☐ No
If **No**, specify how client/patient prefers to be contacted:

_____

Health Card #:_____ Version code:_____

Next of Kin: _____
(last name, first name)

Substitute Decision Maker (if different from Next of Kin):

_____
(last name, first name)

Relationship to client/patient: _____

Address:_____

_____

Tel:_____

Referring Source Information

Name:_____
(last name, first name)

Check one: ☐ Family Physician
☐ Nurse Practitioner
☐ Psychiatrist
☐ Other (specify) _____

Tel:_____

Fax:_____

Address:_____

_____

_____

_____

Billing Number **(if referred by physician)**:

_____

Is client/patient's current psychiatrist aware of referral (**if not referred by a psychiatrist)**?

☐ Yes ☐ No ☐ Unknown

☐ Does not have psychiatrist

Name of Psychiatrist (if applicable):

_____
(last name, first name)

Does the referring source wish to receive a consultation report? ☐ Yes ☐ No

Is client/patient (or substitute decision maker) aware of and in agreement with the referral and that he/she will be seen? (check one): ☐ Yes ☐ No (If **No**, please explain): _____

Is there a need for an interpreter (e.g., for sign language or other language)?
☐ No ☐ Yes (please specify):_____

Are there any other barriers to communication and/or accessibility with this client/patient?
☐ No ☐ Yes (please specify):_____

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1. REASON FOR REFERRAL

- ☐ Diagnostic clarification
- ☐ Medication review
- ☐ Treatment resistance
- ☐ Other

Please specify:

_____

_____

_____

2. WORKING DIAGNOSIS/CLINICAL PROBLEM(S)

WORKING DIAGNOSIS (CHECK ALL THAT APPLY)	SPECIFY CURRENT CLINICAL PROBLEMS	RELEVANT HISTORY
Anxiety ☐	☐ Social ☐ Panic ☐ OCD ☐ Generalized	
Bipolar ☐	☐ Mania ☐ Depression ☐ Mixed Episode ☐ First Episode Mood with Psychosis	
Depression ☐	☐ Hallucinations ☐ Delusions	
Dementia ☐	☐ Memory Issues	
Dual Diagnosis (Intellectual disability plus mental health issues) ☐	☐ Suspected ☐ Requesting Confirmation ☐ Confirmed If confirmed, specify level of intellectual disability as diagnosed by a licensed psychologist: ☐ Mild ☐ Moderate ☐ Severe	
Problem Gambling ☐	Does the client/patient want to address gambling-related concerns? ☐ No ☐ Yes	
Schizophrenia / Spectrum Illness ☐	☐ Hallucinations ☐ Delusions ☐ First Episode Psychosis	
Substance Use ☐	Substance / Amount / Frequency Does the client/patient want to address his/her substance use? ☐ (check if yes)	
Known history of trauma ☐	Please specify:	
Known history of personality disorder ☐	Please specify:	

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3. RISK ISSUES

RISK ISSUE	CHECK IF YES	IF YES: WHEN?	DETAILS
Suicide attempt/ideation			
Deliberate self-harm			
Violent behaviour			
Legal involvement			
Addictions issues			
Behavioural issues			
Swallowing problems			
Other (e.g. falls, fire starting, wandering)			

4. CURRENT MEDICATIONS (Psychiatric and Non-Psychiatric) *attach additional information if needed*

MEDICATION	DOSE / FREQUENCY	RESPONSE & ADVERSE EFFECTS

5. PAST MEDICATIONS (Psychiatric and Non-Psychiatric)

MEDICATION	DOSE / DURATION	RESPONSE & ADVERSE EFFECTS

6. CURRENT and PAST PSYCHOTHERAPIES OR OTHER THERAPIES (including alternative therapies)

THERAPY	WHEN / DURATION	OUTCOME/COMMENTS

7. PAST PSYCHIATRIC/ADDICTIONS HOSPITALIZATIONS (attach discharge summaries)

FACILITY	DATES (dd/mm/yyyy)	REASON

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8. RELEVANT MEDICAL HISTORY (e.g. endocrine, neurological, respiratory, cardiac, or other issues)

9. KNOWN ALLERGIES

10. METABOLIC ISSUES

ADDITIONAL INFORMATION
(e.g. client/patient strengths, current and/or past medications; additional medical history; other comments)

Completed by:

_____ _____ Date:_____
(print name and credentials) (signature) (dd/mm/yyyy)

At CAMH we integrate clinical care and research to improve the prevention, diagnosis and treatment of mental health and addiction disorders. Clients/Patients are key to this goal and may be invited to participate in research.