ADULT (18-64) NON-URGENT AMBULATORY MENTAL HEALTH AND ADDICTIONS REFERRAL FORM

PHONE: 519 667-6777 FAX: 519 667-6685

If your client is experiencing a mental health crisis and requires immediate help, advise them to contact REACH OUT (24-hour crisis line): 519-433-2023; or go to their nearest emergency department; or the Canadian Mental Health Association's Crisis Centre located at 648 Huron St. in London.
If your client needs to be seen within 1-2 weeks, please see the Adult (18-64) Urgent Consultation Service (UCS) Mental Health and Addictions Referral Form.

Our program provides an interprofessional, collaborative service between London Health Sciences Centre (LHSC) and St. Joseph's Heath Care (SJHC) London. Our goal is to provide a non-urgent, time-limited, consultative care model for clients and to coordinate access to available resources within LHSC and the community.

☐ If you are a specialist submitting this form, Primary Care Physician has been informed of this referral
☐ Patient does not have a family physician

Inclusion Criteria

- Individuals ages 18 to 64 (Early Intervention/First Episode Programs provide treatment to youth aged 16 and older)
- Serving residents of London and Middlesex County
- Patient has primary care provider or has seen a physician at a walk-in clinic who is agreeable to follow up on recommendations provided

Was this referral discussed with the client? ☐Yes☐ No

Is the client willing to accept services? ☐ Yes ☐ No

Exclusion Criteria

- Court/legal/insurance purposes: Competency Assessment, Forensic Assessments or involvement to satisfy third party requests

Client Information

Last Name:______________________________

First Name:______________________________

Preferred Name:_____________DOB:__________

Preferred Pronoun: ________________________

OHIP #:__________________________VC: _____

Current Address:

City:________________Postal Code: __________

Is interpretation required? ☐ Yes ☐ No

If yes, what language: _______________________

Personal Phone #: ________________________
Vmail? ☐

Alternate Phone #: ________________________
Vmail? ☐

Email:__________________________________

☐ I am a healthcare provider submitting patient information on behalf of a patient. I acknowledge I have obtained informed consent from the patient whose information will be used to make this referral to accept all risks associated with electronic communication including: email and other electronic forms of communication are not secure or confidential forms of communications; unencrypted messages that are sent across the internet could potentially be intercepted and read by unintended parties; and while London Health Sciences Centre and St Joseph's Health Care use anti-virus software to protect all devices, viruses and malware may be unintentionally transmitted.

Does client have a Substitute Decision Maker? ☐Yes ☐ No

SDM name and contact info:

Does client have a community treatment order?☐Yes ☐ No

The personal health information entered on this form is collected, used, disclosed and retained according to Ontario's ***Personal Health Information Protection Act*** and the ***Public Hospitals Act.*** For more information, contact the Privacy Office at London Health Sciences Centre or St. Joseph's Health Care London

Rev 2023/04/03

London Health Sciences Centre — St Joseph's Health Care London

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Please select one of the two following options based on goals for referral:

☐ **Psychopharmacology Consultation only**	☐ **Comprehensive Interdisciplinary Mental Health Assessment**
• Primary Care Physician (PCP) must have initiated medication treatment that has not been effective • Patient is seeking **medication-based treatment only** • In most cases, patient will be seen for a one-time consultation, followed by treatment recommendations to be implemented by patient's PCP *Please use eConsult as the preferred initial route of management. If patient still requires in person assessment, you may complete this form.*	• Patient will first be seen by a clinician for a complete psychosocial assessment, followed by an interdisciplinary team review and assessment by a psychiatrist, if necessary. • **Short-term** (up to 6 months) follow-up may be offered as required • Patient's PCP is required to remain active during this process & patient will be discharged back to their PCP with a treatment plan

Client Name:

OPTIONAL: Request for Specialized Program Instead of Above General Program Options
(Please ensure information <90 days old)

☐ **Adult Eating Disorders Service**	☐ **PEPP – Prevention and Early Intervention Program for Psychosis**	☐ **FEMAP – First Episode Mood Anxiety Program**	☐ **CDP – Concurrent Disorders Program**
Ht(cm):____Wt(kg): _____ Temp: _____ Lay: BP________HR_________ Stand: BP________HR_________ Frequency per week: Exercise____________ Binging____________ Laxative Use________ Vomiting ___________ Patient Condition: ☐ Type1 diabetes ☐ Pregnant **Mandatory Attachments:** ☐ Blood work ☐ ECG	☐ Suspected first episode of psychosis and no significant antipsychotic treatments provided yet ☐ Clients aged 16 – 35 years ☐ No methamphetamine use in the last three (3) months	☐ Mood or anxiety complaint in the absence of prior long-term (viz., 18 months) treatment ☐ Clients aged 16 – 25 years ☐ Less than 18 months lifetime psychiatric medication use (excepting psychostimulants) ☐ No developmental delay or substantial learning disability (i.e. needed an IEP due to learning problems in school) ☐ No traumatic brain injury	The address is in London-Middlesex Y / N Has a suspect or confirmed substance use disorder, gambling disorder, or other addiction Y / N Has a suspect or confirmed major mental illness Y / N Has an existing psychiatrist or care team Y / N Is supported by a community addictions services Y / N

Presenting Symptoms *Check all that apply and provide details below

Primary diagnosis, if known: ____

☐ Depressed Mood ☐ Mania/Hypomania ☐ Anxiety/Panic ☐ Post-traumatic stress ☐ Psychosomatic Symptoms

☐ Gender Dysphoria ☐ Disruptive/Impulse Control Concerns ☐ Personality Disorder Symptoms ☐ OCD ☐ ADHD

☐ Psychotic Symptoms ☐ Eating Disorder ☐ History of violence/aggression

☐ Current substance abuse, specify: ___________________________

☐ Please Provide Details: ____

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Current Safety Risk Factors (Assess and check all that apply)

☐ Active suicidal thoughts ☐ Passive suicidal thoughts ☐ History of suicide attempt(s)

☐ Thought to harm others ☐ History of violence/aggression ☐ Current intentional self-harm behaviours

☐ Behaviour influenced by delusions/command hallucinations ☐ Other, **please** specify:

Previous Mental Health Treatment / Hospitalizations

(Attach psychiatric and diagnostic history, including consult/progress notes, admission notes, discharge summaries, etc.)

☐ It is mandatory to send the list of all current and previous medication trials otherwise referral will be returned

☐ See attachments ☐ See Clinical Connect

Relevant Medical / Developmental History (i.e. developmental delay, epilepsy, dementia, acquired brain injury, etc.)

Psychosocial / Other Issues

☐ Marital/custody ☐ Sexual abuse ☐ Emotional abuse ☐ Financial issues ☐ Housing

☐ Work/school problems ☐ Anger/temper ☐ Grief/traumatic loss ☐ Charges pending ☐ On trial/incarcerated

Was this referral discussed with the client? ☐ Yes ☐ No **Is the client willing to accept services?** ☐ Yes ☐ No

Client Name:

Referring Source Information

Name:________________________Billing #:____________

Phone #:__________________Fax #: _________________

Office Address:

City:______________________Postal Code: ____________

☐ Family Physician/NP ☐ Walk-In Clinic

☐ Other: ______________________________________

Does the client have a current Psychiatrist? ☐ Yes ☐ No

Psychiatrist Name: ________________________________

REFERRING SOURCE SIGNATURE:____DATE:__________________

If you have any inquiries or require clarification regarding this referral form, please contact the Centralized Access Point (CAP), Ambulatory Mental Health and Addictions Program at LHSC (519-685-8500 ext 76777) during business hours (Monday through Friday from 8:30 a.m. – 4:30 p.m., excluding holidays).

To submit this referral, send the completed referral form and relevant attachments to the Centralized Access Point Office at LHSC
FAX: 519-667-6685

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