GRAND RIVER HOSPITAL

MENTAL HEALTH AND ADDICTIONS PROGRAM
850 King St. W., Kitchener, ON N2G 1E8

REQUEST FOR ADULT OUTPATIENT MENTAL HEALTH SERVICE

Select only one of the available options

URGENT RESPONSE (___)	**NON URGENT** **Psychiatric Consultation Clinic (___)** **Psychiatric Consult Addictions (___)** **Psychiatric Consult Geriatrics (___)**
Does not need Emergency/Crisis but is urgent	Single session consultation & recommendation Additional follow-up possible if clinically indicated
Patient is contacted within 2 working days	Wait times will be faxed to you in 2 working days

FAX: 519-749-4456 PH: 749-4300 ext. 2374

Referrals are received Monday to Friday between 8:30 a.m. and 4:00 p.m.
Services are provided to individual's age 18 years and over who reside in the Grand River Hospital catchment area (excludes Cambridge)
****Ensure supporting documentation is faxed with this referral form.****

PHYSICIAN INFORMATION:

Referring Physician: _____

Direct Phone (back line): (___) _____ **Fax: (___)** _____

Physician Billing # _____

PHYSICIAN SIGNATURE: _____

DATE: _____

1. Is patient aware of and agreeable to referral? Yes □

2. Date patient last seen: dd_____m_____yr_____

PATIENT INFORMATION:

Patient Last Name: _____ **First Name:** _____ **Initial:**

Address: _____

Date of Birth: dd_____mm_____yy_____ Gender: Male ( ) Female ( )

OHIP Number: _____ **Version Code:** _____

Phone: Home (___) _____ **Work (___)** _____ **Cell (___)** _____

Permission to leave phone message? Yes □ **No** □

Marital Status: _____ **Is patient employed? ( )Yes ( )No ( ) Disability**

If employed, occupation of patient _____

REQUEST FOR ADULT MENTAL HEALTH SERVICE

Current Psychiatric Presentation (please be specific regarding signs, symptoms, and diagnosis):

High Risk Behaviours	Present	Past	Never	Specify:
Suicide attempts				
Suicidal ideation				
Self-harm behaviour				
Homicidal Ideation Violence, Acts of Aggression				
Criminal charges Probation				
Substance Abuse (alcohol & drugs)				

Reason for URGENT Response Referral: (Do not complete for referrals for Psychiatric Consultation)

REQUEST FOR ADULT MENTAL HEALTH SERVICE

Has the patient been a Psychiatric Patient? Inpatient ( ) Outpatient ( ) No ( )
Please specify where and when service was provided (Include any documentation including GRH notes)

Relevant Medical History

Other Relevant Information

Current Medications

History of Drug Interactions/Negative Side Effects

Allergies

Thank you for completing this referral form