GRAND RIVER HOSPITAL
Advancing Exceptional Care

MENTAL HEALTH AND ADDICTIONS PROGRAM
850 King Street, West, 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 (___)**
Does not need Emergency/Crisis but is urgent. Patient is contacted within 2 working days.	*Single session consultation & recommendations. Additional follow-up possible if clinically indicated. Referring physician notified with date and time.*

In general, psychiatric follow-up care will include a visit every 1-4 weeks over a period of 3-6 months. The frequency and duration of involvement will be determined by the psychiatrist and care will be discharged back to the referring physician

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

Referrals are received Monday to Friday between 8:00 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.
Please 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 □ No □

2. Date patient last seen: dd_____mm_____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 (please circle)	Past	Never	Specify:
Suicide attempts	Yes / No			
Suicidal ideation	Active / Passive			
Self-harm behaviour	Active / Passive			
Homicidal Ideation	Active / Passive			
Violence, Acts of Aggression	Yes / No			
Criminal charges Probation	Yes / No			
Substance Abuse (alcohol & drugs)	Yes / No			

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)

Relevant Medical History

Other Relevant Information

Current Medications

History of Drug Interactions/Negative Side Effects

Allergies

Thank you for completing this referral form