INFORMATION FOR REFERRAL SOURCE

1) Please complete the following:

   REFERRAL FORM **-Page 2 & 3** (completed by referral source)

   PATIENT FORM **-Page 4** (completed by patient)

2) Please include all relevant reports, labs, tests, medication lists, consultations, etc.
3) Incomplete referrals will be returned
4) We will send a consultation note once the patient has been seen
5) Please fax completed psychiatric referral to: **(705) 688-7770**

INFORMATION FOR PATIENT

1) Your referral will be sent to the **Psychiatric Outpatient Clinic at 680 Kirkwood Drive**
2) You will receive a call from the program to schedule an appointment
3) Please contact us at (705) 675-5900 extension 8234 if there is any change to your contact information
4) Please bring ALL of your medication bottles, including those for other medical conditions
5) Please arrive 10 minutes before your appointment time to register

IMPORTANT

1) If the patient is in crisis, please present to:
   City of Greater Sudbury- 127 Cedar Street or the Emergency Department
   All other communities- your closest Emergency Department

2) The Psychiatric Outpatient Clinic **does not accept any urgent** referrals

Referral Date: _____

ADULT -PSYCHIATRIC OUTPATIENT CLINIC
Referral Form (18 & older)

To Be Completed By Referral Source (1 of 2)

PATIENT NAME: _____

Address: _____

City: _____

Postal Code: _____

DOB: _____ **AGE**:_____

Health Card#: _____

CONTACT INFO:

Tel: _____

Cell: _____

Gender: ❒ Female ❒ Male ❒ Non binary

Language: ❒ English ❒ French ❒ Other _____

Is patient agreeable to the referral? ❒ Yes ❒ No

ALTERNATIVE CONTACT:

Name: _____

Relationship to patient: _____

Tel: _____

REFERRAL SOURCE: _____

Address: _____

City: _____

Postal Code: _____

Tel: _____

Fax: _____

CHECK ONE:

❒ Family Physician ❒ Nurse Practitioner

❒ Other: _____ **BILLING** #: _____

Has the patient seen a psychiatrist before?
☐Yes ☐ No If yes, who: _____

Any admission to psychiatry in the past?
☐Yes ☐ No If yes, when:_____

Are you requesting a specific psychiatrist?
☐Yes ☐ No If yes, who: _____

Please list any mental health or addictions program your client may be involved with:

_____

To Be Completed By Referral Source (2 of 2)

PATIENT NAME: _____

REASON FOR REFERRAL

SUBSTANCE USE

RELEVANT MEDICAL & TREATMENT HISTORY

RISK ISSUE	**CHECK**	**WHEN?**	**DETAILS**
Suicide attempt/Ideation	❒Yes ❒No		
Deliberate Self- harm	❒Yes ❒No		
Violent Behaviour	❒Yes ❒No		
Legal Involvement	❒Yes ❒No		

CURRENT MEDICATIONS LIST ATTACHED ❒Yes ❒No			
Medications	**Current**	**Dose**	**Response and Adverse Effects**
	❒Yes ❒No		
	❒Yes ❒No		
	❒Yes ❒No		

Health Sciences North/ Horizon Santé Nord

To Be Completed By Patient/ À remplir par le (la) patient(e)

PATIENT NAME/ NOM DU (DE LA) PATIENT(E) : _____

Address/ Adresse: _____ **City/ Ville:** _____

Postal Code/ Code postal: _____ **Email/ Courriel:** _____

Tel/ Tél: _____ **Cell:** _____

Can we leave confidential message? Pouvons-nous laisser un message confidentiel? ❒ Yes/Oui ❒ No/Non

Preferred name/name change, if different from above: _____
Nom préféré, changement de nom (si différent de celui ci-dessus)

PLEASE COMPLETE TO THE BEST OF YOUR ABILITY/ VEUILLEZ REMPLIR CETTE SECTION DU MIEUX QUE VOUS LE POUVEZ :

1) Do you think you need to see a psychiatrist? / À votre avis, avez-vous besoin de consulter un psychiatre?
❒ Yes/ Oui ❒ No / Non -If yes, why? / Si oui, pourquoi? _____

2) Are you being pressured to see a psychiatrist? / Vous pousse-t-on à consulter un psychiatre?
❒ Yes / Oui ❒ No/ Non - If yes, why? / Si oui, pourquoi? _____

3) Do you have a previous diagnosis(s)? / Avez-vous reçu un diagnostic dans le passé?
❒ Yes / Oui ❒ No/ Non - If yes, what? / Si oui, quoi? _____

4) Family history of mental illness or addictions? / Y a-t-il de la maladie mentale ou de la toxicomanie dans votre famille?
❒ Yes / Oui ❒ No/ Non - If yes, what? / Si oui, quoi? _____

5) Have you ever been seen by a psychiatrist? / Avez-vous déjà consulté un psychiatre?
❒ Yes / Oui ❒ No/ Non - If yes, why? / Si oui, pourquoi? _____

6) Mental Health or Addiction Programs in the past? / Avez-vous déjà participé à un programme de santé mentale ou de toxicomanie?
❒ Yes / Oui ❒ No/ Non - If yes, which program(s)? / Si oui, quel(s) programme(s)? _____

7) Do you have any issues with substances (drugs)? / Avez-vous des problèmes de consommation de substances (drogues)?
❒ Yes / Oui ❒ No/ Non

8) Do you have any issues with alcohol? / Avez-vous des problèmes de consommation d'alcool?
❒ Yes / Oui ❒ No/ Non

9) What is your current relationship status? / Quel est votre statut de relation en ce moment? _____

10) Longest period your relationship has lasted? / Combien de temps a duré votre plus longue relation? _____

11) Do you live alone or with other members in the home? / Habitez-vous seul(e) ou avec d'autres personnes?_____

12) What is the longest period you have stayed in a job? / Quelle est la plus longue période pendant laquelle vous avez occupé un emploi?_____

13) What is your source of income? / Quelle est votre source de revenus? _____

14) Highest level of education completed? / Quel est le plus haut niveau de scolarité que vous avez terminé?_____

15) What are your current emotional supports? / Quelles sont vos sources de soutien émotionnel en ce moment?
_____