



Insert Patient Demographics Sticker here

INFORMATION FOR REFERRAL SOURCE

- 1) Please complete the following:
REFERRAL FORM -Page 2 & 3 (completed by referral source)
- 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**

INFORM YOUR PATIENT OF THE FOLLOWING

- 1) The referral will be sent to the **Psychiatric Outpatient Clinic (POC) at 680 Kirkwood Drive**
- 2) They will receive a call from the program to schedule an appointment
- 3) Contact the clinic directly at (705) 675-5900 extension 8234 if there is any change to their contact information
- 4) Bring a list of their medications, including those for other medical conditions and over the counter medications
- 5) Arrive 10 minutes before their appointment time to register

IMPORTANT

- 1) The Psychiatric Outpatient Clinic **does not accept any urgent** referrals
- 2) If the patient is in crisis, please present to:
 - The Crisis Intervention Program 24/7 at 705-675-4760 for support (City of Greater Sudbury)
 - The general crisis line at 988 for all other communities
- 3) The POC clinic is no longer accepting re-referrals within 1 year for new client consults that did not attend.



Referral Date: _____

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

To Be Completed By Referral Source (1 of 2)

| | |
|--|--|
| <p>PATIENT NAME: (Last): _____</p> <p>(First): _____</p> <p>Address: _____</p> <p>City: _____</p> <p>Postal Code: _____</p> <p>DOB: _____</p> <p>AGE: _____</p> <p>Health Card#: _____</p> <p>Gender: <input type="checkbox"/> Choose not to disclose</p> <p><input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p><input type="checkbox"/> Non-Binary/Gender Diverse</p> <p><input type="checkbox"/> Transgender Male/Female</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Transgender Female/ Male</p> <p>Language: <input type="checkbox"/> English <input type="checkbox"/> French</p> <p><input type="checkbox"/> Other _____</p> <p>Is patient agreeable to the referral?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><u>CONTACT INFO:</u></p> <p>Tel: _____</p> <p>Cell: _____</p> <p>Email: _____</p> <p><u>ALTERNATIVE CONTACT:</u></p> <p>Name: _____</p> <p>Relationship to patient: _____</p> <p>Tel: _____</p> | <p>REFERRAL SOURCE: _____</p> <p>Address: _____</p> <p>City: _____</p> <p>Postal Code: _____</p> <p>Tel: _____</p> <p>Fax: _____</p> <p>Goal of Referral: <input type="checkbox"/> Diagnosis <input type="checkbox"/> Second Opinion</p> <p><input type="checkbox"/> Treatment Recommendations</p> <p><u>CHECK ONE:</u></p> <p><input type="checkbox"/> Family Physician <input type="checkbox"/> Nurse Practitioner</p> <p><input type="checkbox"/> Other: _____ BILLING #: _____</p> <p>Has the patient seen a psychiatrist before?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who: _____</p> <p>Any admission to psychiatry in the past?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when: _____</p> <p>Please list any mental health or addictions program your client may be involved with:</p> <p>_____</p> <p>_____</p> <p>Please list any special considerations (3rd party insurance, accessibility, barriers, tips for care delivery):</p> <p>_____</p> <p>_____</p> |
|--|--|

Health Sciences North/ Horizon Santé Nord



SRREFPOC

To Be Completed By Referral Source (2 of 2)

PATIENT NAME: _____

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|---|
| NAME OF SUSPECTED DIAGNOSIS/PROBLEM TRIGGERING REFFERAL |
| *Please attach all relevant laboratory and diagnostic investigations from the last 6 months . |

| |
|--|
| MEDICAL HISTORY AND ALLERGIES |
| ALLERGIES: <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, please specify): |
| SOCIAL HISTORY |
| FAMILY HISTORY |
| TREATMENTS |

| RISK ISSUE | CHECK | WHEN? | DETAILS |
|--------------------------|---|---|---------|
| Suicide attempt/Ideation | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Past History <input type="checkbox"/> Ongoing | |
| Deliberate Self- harm | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Past History <input type="checkbox"/> Ongoing | |
| Violent Behaviour | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Past History <input type="checkbox"/> Ongoing | |
| Legal Involvement | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Past History <input type="checkbox"/> Ongoing | |

| CURRENT MEDICATIONS LIST ATTACHED <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
|---|--|------|------------------------------|
| Medications | Current | Dose | Response and Adverse Effects |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Personal Health information that is medically relevant has not been disclosed at the request of the patient.