Peterborough Regional Health Centre
Mental Health & Addictions Services Referral

Patient Label

Date of Referral: _____
(DD/MM/YYYY)

K#_____ Status_____

Please note this is not a crisis service. If you need immediate support please call Four County Crisis at 705-6484 or 1-866-995-9933 or visit the hospital emergency department nearest you. We do not conduct assessments for legal or child custody purposes or insurance claims.

CLIENT INFORMATION:

Name: _____OHIP#: _____ DOB (DD/MM/YYYY): _____Gender: ☐ Male ☐ Female

Address: (include Apt #) _____

Method of contact: (Choose all that you consent to) ☐ Mail ☐ Cell # _____ ☐ Home Phone # _____

Can we leave a message? ☐ Yes ☐ No

Next of Kin: _____Relationship to Client: _____ Phone #: _____

Language: _____ Is an interpreter required? ☐ Yes ☐ No Is client aware of this referral? ☐ Yes ☐ No

Are any of the following responsible for medical decisions? ☐ Power of Attorney ☐ Substitute Decision Maker ☐ Trustee

Name of contact: _____

PRESENTING PROBLEMS:
(symptoms, duration, severity and contributing factors)
GAD 7 score: _____**PHQ9 Score:** _____
Diagnostic Impressions:

REFERRING SOURCE NAME: _____
Telephone #: _____
Fax: _____
Billing #: _____
Referral Signature: _____
PRIMARY PHYSICIAN: Name: _____
Telephone #: _____ **Fax:** _____
Billing #: _____

REASON FOR REFERRAL: (symptoms, duration and goal, etc.)

Impact on daily functioning: ☐ Mild ☐ Moderate ☐ Severe

PLEASE INDICATE WHICH PROGRAM THIS REFERRAL IS DIRECTED TO: Each program requires a separate referral. ONLY check boxes available for requested program ie Urgent/Elective only available in PASE

Adult Out Patient Program (AOP): Contact information: Telephone: 705-876-5028 Fax: 705-876-5013

☐ **Psychiatric consultation (Assessment & treatment recommendations)** ☐ **Telephone Consultation between Primary Care provider & Psychiatrist –** approximately 2-4 weeks

☐ **Anxiety Management Group** ☐ **Emotion Regulation Group** ☐ **Depression Education Group** ☐ **Bipolar Group**
☐ **Mindfulness Group**

☐ **Family & Youth Clinic (FYC)** ☐ **Eating Disorders** ☐ **Urgent Care Clinic**

Contact information: Telephone: 705-876-5114 Fax: 705-876-5040

If parents separated, give name & telephone for both: Name: _____ Contact number: _____
Name: _____ Contact number: _____

☐ **LYNX Early Psychosis Intervention Program (EPI): Contact Information: Telephone: 705-876-5071 Fax: 705-876-5010**
Experiencing first possible break / symptoms of psychosis & aged 14 – 35 years

Psychosis Assessment & Treatment Clinic (PATC) Contact Information: Telephone: 705-876-5071 Fax: 705-876-5010
(formerly Schizophrenia clinic)
☐ **Psychiatry** ☐ **Psychosocial Programs** ☐ **Clinical case management**

Psychiatric Assessment Services for the Elderly (PASE): Contact information: Telephone: 705-876-5076 Fax: 705-876-5160
(Over age 65 years)
☐ Urgent ☐ Elective **Please include medical work up & reports**

OFFICE USE ONLY

Date client called: _____ 30 day expiry date: _____
Booked with:_____
Appointment date:_____ time:_____ Method of contact:_____ ☐ Cancelled ☐ DNA
Appointment date:_____ time:_____ Method of contact:_____ ☐ Cancelled ☐ DNA

CURRENT MEDICATIONS (Psychiatric) attach additional information if needed

Medication	Dose / Frequency	Response & Adverse Effects

Past Medications (Psychiatric*)*

Medication	Dose / Frequency	Response & Adverse Effects

Allergies:

Past Psychiatric Assessments or Therapies ☐ **Yes** ☐ **No** ☐ **Documents attached to referral form**
Please note, in order to process referral request any previous psychiatric assessments or therapy reports/documents must be attached to referral form
Practioner: _____ **Date:** _____
Practioner: _____ **Date:** _____

If your patient is in crisis and at imminent risk of self harm or suicide please direct the patient to the PRHC Emergency Department for assessment by the Crisis Response Team. You may also want to provide your patient with contact number for 4 County Crisis at 705-745-6484 or 1-866-995-9933 for 24 hour telephone crisis intervention.

1. **Suicidality:**
   Ideation: ☐ No ☐ Active ☐Passive
   Plan: ☐ No ☐ Yes
   Attempts:
   Date of last attempt:
   Lethality of attempts: ☐ Low ☐ Moderate ☐ High
2. **Harmful Behaviour:** ☐ Current ☐ Past ☐ Unknown
   Toward self? ☐ No ☐ Yes
   Explain:
3. **Aggressive Behaviour**: ☐ Current ☐ Past ☐ Unknown
   Toward others? ☐ No ☐ Yes
   Explain:
4. **Trauma History**: ☐ Current ☐ Past ☐ Unknown
5. **Family Issues:**
6. **Medical Issues**:
7. **Cognitive functioning:** ☐ Normal ☐ Impaired
   Developmentally Impaired? ☐ Yes ☐ No
8. **Previous mental health history (including FHT mental health therapists) :** ☐ **Attach reports**
   Presenting Problem (Dates/Hospitalized?)
9. **Family Psychiatric History**: ☐ Yes ☐ No
10. **Addictions/Substance Use** (alcohol, drug, gambling, other):
    ☐ Current Use ☐ Past Use
    Type/Quantity/Frequency
11. **Legal Charges/Involvement:** ☐ No Current: ☐ Yes
    Describe:

Other involved Care Providers: (GP, NP, Psych, CMHA, FHT Mental Health therapist, CCAC, etc.)

12. Referrals/Waitlisted for other services? ☐ Yes ☐ No

Peterborough Regional Health Centre is Scent Free and requests that all people entering the building refrain from wearing products with scents/fragrances within the Health Centre environment.