



200 Fletcher Crescent
 Alliston, Ontario L9R 1W7
 Tel: 705-434-5140
 Fax: 705-434-5150

STEVENSON
 MEMORIAL HOSPITAL



**MARY McGILL COMMUNITY MENTAL HEALTH PROGRAM
 OUTPATIENT REFERRAL**

Outpatient Referral - Fax to: 705-434-5150

Tel: 705-434-5140

*Please print clearly and include any relevant medical/psychiatric reports or summaries.
 INCOMPLETE REFERRALS WILL NOT BE PROCESSED.*

Referral Date: (dd/mm/yy)		
Referral Source (Name):		
<input type="checkbox"/> GP	<input type="checkbox"/> PSYCHIATRIST	<input type="checkbox"/> SMH RN/NP
<input type="checkbox"/> ER	<input type="checkbox"/> OTHER (specify):	
Phone	Fax#:	Email:
Family Physician Name:		

NOTE: CHOOSE SERVICE THIS REFERRAL IS INDICATED FOR:	
COUNSELLING CLINIC <input type="checkbox"/> Individual Counselling <input type="checkbox"/> Group Counselling	URGENT CLINIC (counselling only) <input type="checkbox"/> (Contact Main Clinic # & Fax referral)

<input type="checkbox"/> Psychiatric Consult / Assessment (Referring Physician's OHIP billing # _____)

CLIENT / PATIENT INFORMATION			
Patient Name:		D.O.B. (dd/mm/yy) ____/____/____	
Address:			
Fire #:	Lot:	Conc.:	Township:
Home Phone:		<input type="checkbox"/> Ok to leave a message	
Cell Phone:		<input type="checkbox"/> Ok to leave a message	
Bus. #		<input type="checkbox"/> Ok to leave a message	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Health Card #:	Version code:	

DIAGNOSIS: Axis I _____
Axis II _____
Axis III _____

PRESENTING PROBLEM:

WE DO NOT ACCEPT REFERRALS PRIMARILY DEALING WITH COMPENSATION/INSURANCE ISSUES OR COURT ORDERED TREATMENT.





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PATIENT LABEL

MARY MCGILL COMMUNITY MENTAL HEALTH PROGRAM

OUTPATIENT REFERRAL Continued

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Risk Issues/Any History As Follows? Yes No If Yes, when? _____

Comments:

Criminal Charges

Violent Behaviour

Suicidal Attempts

Substance Abuse Hx

Other Self Harm Behaviour

MEDICATIONS		
Psychiatric/Nonpsych.	Dose/Frequency	Comments

CURRENT AND PAST PSYCHOTHERAPIES		
Therapy	When/Duration	Outcome

FOR OFFICE USE ONLY	
Date Rec'd: (dd/mm/yy) ____/____/____	Contacted: <input type="checkbox"/> Yes <input type="checkbox"/> No
Phone Screen Date: ____/____/____	Referral Declined: <input type="checkbox"/> By Client <input type="checkbox"/> By Progr.
Redirected to:	
Staff name:	

