Psychiatric Consultation Intake Package

Mary McGill Community Mental Health Program

INCOMPLETE REFERRALS WILL NOT BE PROCESSED

FAX TO: 705-434-5150

Adult mental health (16 years +)

Consultation includes: Initial consult, medication stabilization and referral back to family physician

Referral Date

Month Day Year

Referral Source and OHIP Billing #

Client/Patient Information

Name

First Name Middle Name Last Name

D.O.B

Month Day Year

Address

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

0

Country

Home Phone:

Area Code Phone Number

Ok to leave a message -

Cell Phone

_____ _____
Area Code Phone Number

Ok to leave a message -

Sex:

- ❑ Male
- ❑ Female
- ❑ Prefer not to identify

Health Card # (include version code) _____

Living Arrangment -

Marital Status _____

Number of Children _____

Sources of Income -

Level of Employment -

Education Status -

Do you have a WSIB or insurance claim at this time?

- ❑ Yes
- ❑ No

Criminal Involvement/Current legal status

Risk Issues

Risk issues/history as follows?

- ❑ Yes
- ❑ No

Criminal Charges

- ❑ Yes
- ❑ No

If Yes, provide details

Violent Behaviour

- ❑ Yes
- ❑ No

If Yes, provide details

Suicidal/homicidal ideations

- ❑ Yes
- ❑ No

Previous Attempts/Details

Substance Abuse History

- ❑ Yes
- ❑ No

If Yes, please provide details, including when and duration of use

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Other self harm behaviour

- ❍ Yes
- ❍ No

If Yes, provide details

Personal Substance Use

Alcohol

Drugs

Presenting Issues

Diagnosis

Axis I

Axis II

Axis III

Presenting Problem

When was the last time you felt ok?

What are you looking for in coming here?

History

Medical History

Personal Medical History

Family Medical History

Psychiatric History

Personal Psychiatric History

Family Psychiatric History

Have you experienced or are presently experiencing any trauma?

- ❑ Physical
- ❑ Sexual
- ❑ Psychological
- ❑ Emotional

Medications (please include name, dosage and years of use)

Allergies

Please leave a contact email address for the referring physician's office in the event that additional information is required.

E-mail _____

FOR OFFICE USE ONLY

Date received _____ _____ _____
Month Day Year

Contacted
- ❍ Yes
- ❍ No

Phone screen date _____ _____ _____
Month Day Year

Referral declined
- ❑ By client
- ❑ By program

Redirected to _____

Staff name _____