STEVENSON MEMORIAL HOSPITAL

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

PATIENT LABEL

MARY McGILL COMMUNITY MENTAL HEALTH PROGRAM
OUTPATIENT REFERRAL

Our outpatient Mental Health Program accepts referrals where there is a primary Psychiatric concern. We provide CONSULTATION ONLY. Upon receipt of your completed referral our team will review and determine how best to serve your patient. If appropriate, they will be contacted to complete the screening process. Referrals that are not completed will be returned.

CLIENT/PATIENT INFORMATION:		
Last Name	First Name	Sex ☐ Male ☐ Female ☐ Other
Address (street)		
City/Town		Postal Code
Home Phone #	Cell #/Other	
Date of Birth (yyyy/mm/dd)	Health Card Number	Version Code
Is the patient aware and supportive of this referral? ☐ Yes ☐ No		

ALL REFERRALS WILL BE SCREENED FOR APPROPRIATENESS

We are NOT able to accept referrals for Assessment where concerns are related primarily to: Legal, Insurance, Custody, Children's Aid Society (CAS), Workplace Safety and Insurance Board (WSIB) or Forensic reasons.

SERVICE REQUEST: ☐ Psychiatry Consultation ☐ Referral to Individual Counselling

Clinical Features: (Please check all that apply)

☐ Depression/Mood Symptoms
☐ Manic/hypomanic Symptoms
☐ Panic Attacks
☐ Significant Relationship problems
☐ Sleep Disturbance
☐ Hyper Deficit/Hyperactivity
☐ Significant substance Use
What?_____
How long?_____

☐ Inability to cope with life stressors
☐ Anxiety
☐ Hallucinations/delusions
☐ Obsessive/Compulsive Behaviours
☐ Decrease in self-care
☐ Other (please specify)
_____
_____

Please Note: If primary is substance use problem, please refer to OATC Alliston, 705-250-5100

Serious Risk Factors:	**Present**	**Past**
Suicide Ideation	☐	☐
Suicide Attempt	☐	☐
Police Involvement	☐	☐
Violent Behaviours	☐	☐
Other Self Harm Behaviours	☐	☐

PRESENTING PROBLEM/ADDITIONAL NOTES: (Please describe in detail any clinical features or risk factors identified above)

_____
_____
_____
_____

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OUTPATIENT REFERRAL

Medical Conditions:

_____

_____

_____

Current Medications:

Name/Type	Dosage	When initiated

Any Adverse Drug Reactions/Known Allergies?

_____

Mental Health Treatments and/or Psychiatric Admissions in past two years

	What	Where	When
1.			
2.			
3.			

REFERRAL INFORMATION:

Family Physician/Nurse Practitioner:	Billing Number:
Phone:	Fax:
Signature:	Date:

If you have a concern that a patient is actively suicidal please direct them to the Nearest Emergency Department.

Additional resources that may be able to accommodate more urgent referrals:
Southlake Regional Health Centre
Dept of Psychiatry
905-853-3103 Ext. 2070

CMHA York/south Simcoe
Rapid Access Psychiatry Program
rapreferral@cmha-yr.on.ca
1-866-0183 Ext. 3321

Waypoint Centre for Mental Health – Forms can be obtained through their website.

Geriatric Psychiatry Referrals can be sent to CMHA/Loft integrated Psychogeriatric Outreach Program (IPOP) through Central Access at 1-844-798-6920.