Mackenzie Health

Mackenzie Richmond Hill Hospital
10 Trench Street, Richmond Hill ON L4C 4Z3
905-883-1212

Cortellucci Vaughan Hospital
3200 Major Mackenzie Drive West, Vaughan ON L6A 4Z3
905-417-2000

Mental Health Adult Outpatient Referral Form

Central Intake: 905-883-2127
Fax: 905-883-2139

The Outpatient Mental Health Program accepts referrals where there is a primary psychiatric concern. We provide short term consultation and stabilization. Upon receipt of your completed referral, our central intake team will review and determine how to best serve your patient. If our central intake team determines that your patient requires urgent intervention, our goal is to see them within 14 days.

We are NOT able to accept referrals for assessments/treatment where concerns are related principally to:

Adult ADHD	Chronic Pain	Primary Substance Abuse
Anger Management	Developmental delay	Relationship Counselling
Autism Spectrum Disorders	Eating Disorder	Domestic Sexual Trauma

We do not provide assessment for Legal, Insurance, Custody, CAS, WSIB or Forensic reasons.

Is the patient involved in current/pending legal, compensation or insurance claims? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

CLIENT INFORMATION: Date patient was last seen? _____ (dd/mm/yyyy)

Is patient agreeable to referral? ☐ Yes

Patient Name: (Last, First Name)		**Date of Birth:** (dd/mm/yyyy)
Address:		
Sex: ☐ Male ☐ Female	**Health Card Number:**	**Version Code:**
Home #:	*Can we leave a message at this number? ☐ Yes ☐ No	
Cell #:	*Can we leave a message at this number? ☐ Yes ☐ No	

Email Address of primary contact for referral (required) _____

(Please ensure your patient is aware of regularly check their "Junk" as often email servers are filtering the hospital emails to "Junk" due to their settings)

Due to Privacy Legislation to hospital requires this field to be completed before the patient can be contacted.

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

(This information is required by the hospital to register the patient)

REFERRAL INFORMATION: Referrals must be made by a physician

Referred by: ☐ Family physician ☐ Psychiatrist ☐ Other _____

Referring Physician's Name: _____ **Billing No:** _____

Telephone Number: _____ **Fax Number:** _____

Is there a need for an interpreter (e.g., for sign language or other language) ☐ No ☐ Yes _____

SERVICE REQUEST (Choose ONE)

- ☐ **Psychiatric Consult**
  - ☐ Diagnostic Clarification
  - ☐ Medication Review
- ☐ **Counselling SW/RN Therapist-short term**
- ☐ **Stepping Stones – Day Program**
- ☐ **Psychogeriatric Program**
- ☐ **Neuropsychiatry**

Reason for Referral: Please provide previous consultation notes, (required field). _____

_____

_____

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Central Intake

Current Medications	Past Medications/Side effects if any/Reason for discontinuation

Medical Condition

Must be completed

☐ No Known Allergies Allergies: _____

Factors contributing to current referral

- ☐ appetite changes
- ☐ cognitive changes
- ☐ compulsive behaviours
- ☐ decreased energy
- ☐ decrease in self care
- ☐ depressed mood / sad for more than two weeks
- ☐ sleep changes
- ☐ social withdrawal
- ☐ panic attacks
- ☐ significant anxiety / fears
- ☐ alcohol / drug use
- ☐ racing thoughts
- ☐ psychomotor retardations or agitation
- ☐ delusions
- ☐ hallucinations
- ☐ disorganized thoughts or speech

RISKS			Please explain:
Threat to self	☐No	☐Yes	When:
Threat to others	☐No	☐Yes	When:
Suicidal Ideation /Plan /Intent	☐No	☐Yes	When/Describe:
Violent behavior	☐No	☐Yes	When:

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

Please provide the details for urgency:_____

_____

_____

_____

_____

Incomplete referrals will be returned

Physician Name: _____ Signature: _____ Date: _____(dd/mm/yyyy)

WE WILL CONTACT YOUR PATIENT DIRECTLY