Huron Perth Healthcare Alliance
Outpatient Mental Health Services Referral Form

We have transitioned to a Stepped Care Model for Outpatient Mental Health Services referrals. Services will be offered based on appropriateness, availability, and may include psychiatric consultation and short-term treatment, where appropriate.

Information for Referral Source

- A referral from a Primary Care Provider (Physician or Nurse Practitioner) is ***required*** for Psychiatry
- For certain programs a Primary Care Provider may be required to provide metabolic monitoring
- Endorsement from a Primary Care Provider may be required in any of the Outpatient Mental Health Services Programs
- Information marked “required” on the referral form must be completed in full
- Information requested on the referral form may be sent as a separate attachment if there is insufficient space on the referral form
- The referral source must inform whether subsequent referrals were made to similar programs to avoid duplication
- Right service connection will be facilitated following an intake assessment
- Communication regarding service connection will be provided to the referral source via fax and/or telephone

Note: if a referral needs to be cancelled for any reason, please contact Central Intake at 519-272-8210 extension 2570 or fax 519-272-8226.

Information for Individuals Being Referred

- The individual being referred must be aware that a referral is being made to the Huron Perth Healthcare Alliance (HPHA) Outpatient Mental Health Services
- Appointment booking will be communicated via telephone to the client/caregiver and/or via fax to the referral source
- Right service connection will be facilitated following an intake assessment
- If an individual’s contact information changes, they and/or their Substitute Decision Maker are responsible to notify the program or their Mental Health Clinician
- HPHA’s Central Intake staff will make three attempts to contact the individual by telephone. If contact cannot be made, the file will be closed and the referral source will be notified
- Individuals can contact Outpatient Mental Health Services to receive an update on the status of their referral by calling Central Intake at 519-272-8210 extension 2570

How to Submit the HPHA Outpatient Mental Health Services Referral Form

- Fax the completed Referral Form to **519-272-8226** (each referral must be faxed separately)
- To help us provide the best care possible, please complete **all pages** of the referral form and include all relevant documents, such as previous psychiatric consultations, discharge summaries, medication administration records, psychological/mental health notes, lab and test results, and medical information

Note: To make a referral to the **HPHA Child and Adolescent Psychiatry Program** (individuals between 5 and 17.5 years of age), **Eating Disorders Outreach Program**, **Assertive Community Treatment Team** or **Community Treatment Order Program Referral Form** please complete the program specific referral form, found on the HPHA website, and fax it to **519-272-8226.**

Note: To make a referral to the **Seniors Mental Health & Addiction Response Team**, please complete the **Seniors Mental Health & Addiction Response Team Referral Form,** found on the HPHA website, and fax it to **519-527-8420.**

Note: HPHA Central Intake will notify the Referral Source in writing that the referral forms are incomplete and/or illegible, and provide the Referral Status of Pending Due to Incomplete Documentation notification. The Referral Source will be asked to submit any missing information within **21 days** in order for the referral to be processed by Central Intake. If the required information is not received by this date, **the referral will be closed;** you are welcome to re-refer the individual in future. Re-referrals will be processed by the date that the completed package is received, **not the date of initial inquiry.**

If an individual is in crisis, direct them to the **Huron Perth Helpline and Crisis Response Team** at **1-888-829-7484** or their nearest Emergency Department. If an individual is experiencing an emergency, **9-1-1** should be contacted.

If you have any further questions or concerns, please contact Central Intake at 519-272-8210 extension 2570.

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Outpatient Mental Health Services Referral Form

Date of Referral: ________________ *(DD/MM/YYYY)* **Date Referral Received *(office use only)***: _______________

Referral and Criteria Checklist – Required *(check all that apply)*

☐ **Clozapine Clinic – Psychiatric Day & Evening Program**
- ☐ Registered with Novartis and has a CSAN number
- ☐ Prescribed clozapine by Psychiatrist or Primary Care Provider
- ☐ Able to manage in the community with support
- ☐ Resident of Perth County

☐ **Counselling Services - Psychiatric Day & Evening Program and Listowel Mental Health Outpatient Services**
(Group or Individual Counselling Services offered based on Level of Care established at Intake)
- ☐ 16 years of age or older
- ☐ Ready to engage in goal-orientated therapy
- ☐ Experiencing mental health and/or addiction issues
- ☐ Resident of Perth County

Delivery Preference: ☐ In-Person ☐ Virtual ☐ Either | ☐ Daytime ☐ Evening ☐ Either

☐ **Prevention & Early Intervention Program for Psychoses**
- ☐ 16 to 35 years of age
- ☐ Experiencing symptoms of psychosis or early psychosis:
  - ☐ Hallucinations (auditory, visual or other)
  - ☐ Delusions (paranoia, grandiosity, thought broadcasting and insertion, etc.)
  - ☐ Disorganized thinking (feeling confused, slow or fast thoughts, difficulty concentrating, or following a conversation)
  - ☐ Negative symptoms (apathy, anhedonia, attention, etc.)
  - ☐ Mood symptoms (depressed euphoria, anxious, etc.)
- ☐ Has either received no previous treatment or treatment for 6 months or less for psychosis
- ☐ Has not used methamphetamine for 3 months or longer
- ☐ Resident of Huron or Perth County

☐ **Sexual Abuse Treatment Program**
- ☐ 16 years of age or older
- ☐ Identifies as having experienced a sexual assault
- ☐ Resident of Perth County

☐ **Psychiatry Consultation** – Adult, Psychogeriatric
- ☐ Individual is:
  - ☐ 18 to 65 years of age (Adult)
  - ☐ 65 years of age and older **or** under 65 years of age with cognitive impairment (Psychogeriatric)
- ☐ Referring Primary Care Provider has tried previous interventions that have not been successful at stabilizing the individual
- ☐ Referring Primary Care Provider is willing to provide medical care and ongoing follow-up to their patient
- ☐ Resident of Perth County

Client Demographic Information – Required *(please print)*

Client's Legal Name *(first name, last name)*: ______________________________

Preferred Name *(if different from above)*: ______________________________

Date of Birth *(DD/MM/YYYY)*: __________________ Sex Assignment at Birth: ☐ Male ☐ Female ☐ Intersex

Gender Identity: ______________________ Pronouns: ______________________

Address: ______________________________ ☐ No Fixed Address
(Street, Town, Province, Postal Code)

Telephone: ______________________ *(home/cell/work/other)* Consent to contact by telephone: ☐ Yes ☐ No

Huron Perth Healthcare Alliance
Outpatient Mental Health Services Referral Form

Client Name *(first name, last name)*: ____________________

Consent to leave detailed voicemail: ☐ Yes ☐ No Consent to speak with others in the household: ☐ Yes ☐ No

If yes, please specify *(name/relationship)*: ____________________

Living Arrangements *(self, spouse, parent(s), long-term care, group home, roommate(s) etc.)*: ____________________

Client Health Card Information - Required

Health Card Number: ____________________ Version Code: ____________________

Additional Considerations

☐ Mobility ☐ Audio ☐ Visual ☐ Language ☐ Interpreter Services Required ☐ Service Animal

☐ Other: ____________________ If yes, please explain: ____________________

Primary Care Provider *(if applicable)*

Name: ____________________ Family Health Team (FHT)/Medical Clinic: ____________________

Telephone:____________________ Fax:____________________

Substitute Decision Maker / Caregiver Information *(if applicable)*

By providing this information, the Referral Source confirms that the individual being referred consents for the HPHA to call the Substitute Decision Maker/Caregiver on their behalf. The HPHA will refrain from communicating Personal Health Information until consents are verified.

Name of Substitute Decision Maker / Caregiver: ____________________

Relationship to client: ____________________

Telephone: ____________________ *(home/cell/work/other)* Consent to leave detailed voicemail: ☐ Yes ☐ No

Referral Source Information – *Self or Substitute Decision Maker/Caregiver Referrals only*

Referral is for: ☐ Myself ☐ Dependant Family Member

I am designated to make treatment decisions for this client : ☐ Yes ☐ No

Referral Source Information - Required

HPHA requires the referring Primary Care Provider or the individuals Most Responsible Person to continue to be available for ongoing medical care

☐ Primary Care Provider (PCP) ☐ Emergency Department Physician ☐ Hospitalist ☐ Psychiatrist

☐ Professional Referral ☐ Other: ____________________

I will continue to provide medical care and ongoing follow-up to this client *(required)*: ☐ Yes ☐ No

Name/Agency/Program: ____________________

FHT / Medical Clinic *(if applicable)*: ____________________

Address: ____________________

Telephone:____________________ Fax:____________________

Billing Number *(if applicable)*: ____________________ CPSO Number *(if applicable)*: ____________________

Presenting Concerns – Required *(attach if details cannot fit in the space provided)*

Please provide a brief narrative explaining presenting concerns and symptoms, including duration and frequency of symptoms, psychosocial factors, substance use issues and all other current and historical information that is relevant:

Huron Perth Healthcare Alliance
Outpatient Mental Health Services Referral Form

Client Name *(first name, last name)*: ______________________________

For Psychiatry Consultation Referrals Only

Reason for Consultation
- ☐ Collaborative Care Consultation
- ☐ Psychopharmacology Consultation

Requested Services
- ☐ Treatment Recommendations
- ☐ Diagnostic Clarification with Follow-Up as Clinically Appropriate
- ☐ Episode of Care Follow-Up

Goal of Consultation

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Please provide details, if any, regarding self-harm, violence or aggression, substance use, cognitive impairment, and/or criminal charges:

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Please indicate any current or pending *(check all that apply)*:

- ☐ Community Treatment Order
- ☐ Children's Aid Society (CAS) Involvement
- ☐ Disability or Pension Claim
- ☐ Court/Legal Proceedings
- ☐ WSIB Claim
- ☐ Insurance Claim

Mental Health Services involved in the Past 5 Years – Required *(attach if details cannot fit in the space provided)*

Organization Name: ______________________________

Current Involvement: ☐ Yes ☐ No

Describe Involvement: ______________________________

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Date of Most Recent Psychiatry Assessment: ______________________________

Psychiatry Assessment Completed by: ______________________________

Psychosocial, Accommodation or Risk Factors *(if applicable)*

Home Visit Concerns

Are there any known safety risks staff should be aware of in delivering service? *(such as history of violence/aggression, history of sexual assault, access to weapons, domestic violence, smoking in the residence, animals in the residence)*: ______________________________

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Risk Factors

Past:
- ☐ Suicidal ideation
- ☐ Suicidal ideation with a plan
- ☐ Suicide attempt(s)
- ☐ Self-injurious behaviour(s)
- ☐ Thought to harm others
- ☐ Plan to harm others
- ☐ Aggressive/violent behaviour
- ☐ Delusions or hallucinations
- ☐ Addiction concerns/overdosing history
- ☐ Housing Stability

Present:
- ☐ Suicidal ideation
- ☐ Suicidal ideation with a plan
- ☐ Suicide attempt
- ☐ Self-injurious behaviour(s)
- ☐ Thought to harm others
- ☐ Plan to harm others
- ☐ Aggressive/violent behaviour
- ☐ New/increasing delusions or hallucinations
- ☐ Addictive behaviours
- ☐ Housing Stability

Comments: ______________________________

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Protective Factors

List any known protective factors for this individual *(such as steady employment, stable housing, supportive relationships, engagement in counselling services, involvement in prosocial recreational activities)*: ______________________________

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Huron Perth Healthcare Alliance
Outpatient Mental Health Services Referral Form

Client Name *(first name, last name)*: ______________________________

Medical/Physical Health - Required

Please provide a list and details of any relevant medical/physician considerations (e.g. specific illnesses, chronic pain, difficulty coping with medical illness, etc.)

Allergies: ☐ Yes ☐ No If yes, please specify: ______________________________

Medications - Required ☐ attached

Please include both psychiatric and non-psychiatric medication (dose, frequency, adverse effects), including all current and previously trialed medications. Please attached a medication list if the medications are expansive of the space provided.

Supplemental Information

This information is highly valued and may be requested for certain programs. Please check all that are attached with this referral.

- ☐ Medical/Psychological/Psychiatric History
- ☐ Hospital Discharge Summaries
- ☐ Psychiatric Hospitalization(s)
- ☐ Recent Laboratory Results (e.g. blood work, urinalysis, etc.)
- ☐ Community Treatment Order (current or past)
- ☐ MoCA – **required for all clients over 65 years of age**
- ☐ Other Assessments (e.g. MMSE, DOS, GAIN-SS, PHQ-9, GAD-7): ______________________________

Is the client and/or Substitute Decision Maker/Caregiver aware of this referral: ☐ Yes ☐ No

Does the client and/or Substitute Decision Maker/Caregiver consent to this referral: ☐ Yes ☐ No

Please note, the client and/or Substitute Decision Maker/Caregiver must consent to a referral being made on their behalf to HPHA Outpatient Mental Health Services.

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Name *(PCP, Professional, Self or Caregiver)*

______________________________ ______________________________

Signature *(PCP, Professional, Self or Caregiver)* **Date** *(DD/MM/YYYY)*

Thank you for making a referral to the HPHA Outpatient Mental Health Department. Your involvement in this client's care is important to us; if you have any questions or concerns, or wish to provide updated client information, please contact Central Intake at **519-272-8210 extension 2570** or **by fax 519-272-8226.**