Huron Perth Healthcare Alliance
Outpatient Mental Health Services Referral Form

Information for Referral Source

- A referral from a Primary Care Provider is ***required*** for Psychiatry
- For certain programs a Primary Care Provider (Physician or Nurse Practitioner) 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 (ACTT)** 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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Referral and Criteria Checklist – Required *(check all that apply)*

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

☐ **Group Counselling – Psychiatric Day & Evening Program / Listowel Mental Health Outpatient Services**
- ☐ 16 years of age or older
- ☐ Ready to engage in goal orientated therapy
- ☐ Experiencing mental health and/or addiction issues
- ☐ Resident of Perth County

Group Counselling Program and Delivery Preference:
- ☐ Dialectical Behaviour Therapy – SKILLS Group
- ☐ Cognitive Behaviour Therapy for Anxiety
- ☐ Cognitive Behaviour Therapy for Mood

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

☐ **Individual Counselling – Psychiatric Day & Evening Program / Listowel Mental Health Outpatient Services**
- ☐ 16 years of age or older
- ☐ Ready to engage in goal orientated therapy
- ☐ Experiencing mental health and/or addiction issues
- ☐ Resident of Perth County

☐ **Prevention & Early Intervention Program for Psychoses (PEPP)**
- ☐ 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 Assessment** – Adult, Psychogeriatric
- ☐ Individual is:
  - ☐ 18 to 65 years of age (Adult)
  - ☐ 65 years of age and older (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

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

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 Consent to leave detailed voicemail: ☐ Yes ☐ No

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

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

Household language: ☐ English ☐ French ☐ Other: _____

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: _____ Telephone:_____

Family Health Team (FHT) / Medical Clinic: _____

Service Provider Information *(if applicable)*

Name/Agency/Program: _____ Telephone:_____

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 Caregiver Referrals only

Referral is for: ☐ Myself ☐ Dependant Family Member

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

Consent to leave detailed voicemail: ☐ Yes ☐ No

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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:

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: _____

_____

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)*: _____

_____

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)*:

_____

_____

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.

_____

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.**