Stratford General Hospital Outpatient Mental Health Services
90 John Street South, Stratford ON N5A 2Y8
Fax to 519 272-8226

IMPORTANT: Please note incomplete referral forms will be returned for completion. We DO NOT provide urgent consultations. For urgent consults, patient can be referred to our urgent care clinic. The referring source will be contacted with an appointment and asked to notify their patient. We service clients who are 18 years of age and over and who are residents of Perth County.

Date of Referral: _____

Please fax all:

□ **All past psychiatry assessments**
□ **Medication list**
□**Psychological assessments**
□ **Most recent bloodwork**

Client Information:

Surname:	First Name:	SGH Medical Record# (if available)
Telephone: Alternate phone: OHIP and Version Code		
Address:	Postal Code(required)	Interpreter Required? □yes □no
Gender:	Marital Status:	Permission to leave voicemail? □yes □no Permission to speak with family member/roommate? □yes □no
Date of Birth:		

Referral Source:

Name of Primary Care Provider(PCP)	
PCP Phone Number	
PCP Fax Number	
Clinic/Organization Address	

Please Indicate any current or pending:

Please note the psychiatrists are unable to complete insurance, disability or pension applications/forms

□Community Treatment Order	□ CAS Involvement	□Court/Legal proceedings
□ WSIB Claim	□ Disability or Pension Claim	□Insurance Claim

Please specify the client population:

□ Adult Psychiatry(age 19-64) □ Psychogeriatric (age ≥65) □ Perinatal (estimated date of birth)

Non MD Referral:

Group therapy - □Mind over Mood □ Dialectical Behaviour Therapy □ Panic and Anxiety
□ Psychosocial Rehabilitation Group for Seniors

□One to One counselling

□ Other _____

Please choose <u>ONE</u> referral stream and indicate the reason for consultation:

□ Collaborative Care Consultation:	□ Psychopharmacology Consultation
Comprehensive psychiatric consultations for adults that include detailed treatment. ***Short term*** follow up may be offered and we require that the client's primacy care provider(PCP) remain active in their clients care. When client have completed their episode in our clinic, they are discharged back to the PCP	Offered after PCP has initiated medication treatment that has not been effective and the client is seeking medication-based treatment only. Client will be seen for a limited number of appointments followed by a written report with treatment recommendations.
MANDATORY: Reason for consultation – please indicate the goal for consultation and check a box below if applicable. Working DSM-5 diagnosis	
□Treatment Recommendations □ Patient is on or needs to be on medication that you do not regularly Start □Diagnostic clarification □ Patient has a psychiatric condition that you rarely see in practice □Episode of care follow-up □ Patient is treatment refractory	

Please indicate past history of:(please specify and attach any relevant documents)

Self Harm/Suicidality	□No □Yes**:**
Violence or Aggression	□ No □ Yes:
Substance Use	□No □Yes:
Cognitive Impairment	□No □Yes:
Criminal Charges	□No □Yes:

Psychiatric/Medical History: (please specify and attach all relevant documentation)

Previous Psychiatric Diagnosis	**□ No □ Yes**
Past hospitalizations and/or psychiatric treatment	**□ No □ Yes**
Medical Diagnoses/Problems(including investigations in progress	**□ No □ Yes**
Allergies	**□ No □ Yes**
Current Case Manager, Counselor or Therapist	**□ No □ Yes If yes please give name, agency and phone number of worker**

Capacity

Financial	□ Yes □ No	SDM/POA:
Treatment	□ Yes □ No	SDM/POA:

Preferred Pharmacy_____

Allergies: _____

History of Drug Interactions: _____

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