ADULT (18-64) NON-URGENT AMBULATORY MENTAL HEALTH AND ADDICTIONS REFERRAL FORM

PHONE: 519 667-6777 FAX: 519 667-6685

If your client is experiencing a mental health crisis and requires immediate help, advise them to contact REACH OUT (24-hour crisis line): 519-433-2023; or go to their nearest emergency department; or the Canadian Mental Health Association's Crisis Centre located at 648 Huron St. in London.
If your client needs to be seen within 1-2 weeks, please see the Adult (18-64) Urgent Consultation Service (UCS) Mental Health and Addictions Referral Form.

Our program provides an interprofessional, collaborative service between London Health Sciences Centre (LHSC) and St. Joseph's Heath Care (SJHC) London. Our goal is to provide a non-urgent, time-limited, consultative care model for clients and to coordinate access to available resources within LHSC and the community.

☐ If you are a specialist submitting this form, Primary Care Physician has been informed of this referral
☐ Patient does not have a family physician

Inclusion Criteria

- Individuals ages 18 to 64 (Early Intervention/First Episode Programs provide treatment to youth aged 16 and older)
- Serving residents of London and Middlesex County
- Patient has primary care provider or has seen a physician at a walk-in clinic who is agreeable to follow up on recommendations provided

Was this referral discussed with the client? ☐ Yes ☐ No

Is the client willing to accept services? ☐ Yes ☐ No

Exclusion Criteria

- Court/legal/insurance purposes: Competency Assessment, Forensic Assessments or involvement to satisfy third party requests

Client Information

Last Name: _____

First Name: _____

Preferred Name: _____ DOB: _____

Preferred Pronoun: _____

OHIP #: _____ VC: _____

Current Address:

City: _____ Postal Code: _____

Is interpretation required? ☐ Yes ☐ No

If yes, what language: _____

Personal Phone #: _____
Vmail? ☐

Alternate Phone #: _____
Vmail? ☐

Email: _____

☐ I am a healthcare provider submitting patient information on behalf of a patient. I acknowledge I have obtained informed consent from the patient whose information will be used to make this referral to accept all risks associated with electronic communication including: email and other electronic forms of communication are not secure or confidential forms of communications; unencrypted messages that are sent across the internet could potentially be intercepted and read by unintended parties; and while London Health Sciences Centre and St Joseph's Health Care use anti-virus software to protect all devices, viruses and malware may be unintentionally transmitted.

Does client have a Substitute Decision Maker? ☐ Yes ☐ No

SDM name and contact info:

Does client have a community treatment order? ☐ Yes ☐ No

Reason for Referral and Goals for Treatment

Reason/Goals for Referral (Required): _____

_____

Please select one of the two following options based on goals for referral:

☐ **Psychopharmacology Consultation only**

- Primary Care Physician (PCP) must have initiated medication treatment that has not been effective
- Patient is seeking **medication-based treatment only**
- In most cases, patient will be seen for a one-time consultation, followed by treatment recommendations to be implemented by patient's PCP

Please use eConsult as the preferred initial route of management. If patient still requires in person assessment, you may complete this form.

☐ **Comprehensive Interdisciplinary Mental Health Assessment**

- Patient will first be seen by a clinician for a complete psychosocial assessment, followed by an interdisciplinary team review and assessment by a psychiatrist, if necessary.
- **Short-term** (up to 6 months) follow-up may be offered as required
- Patient's PCP is required to remain active during this process & patient will be discharged back to their PCP with a treatment plan

Client Name:

OPTIONAL: Request for Specialized Program Instead of Above General Program Options
(Please ensure information <90 days old)

☐ **Adult Eating Disorders Service**

Ht(cm):____Wt(kg): _____

Temp: _____

Lay: BP_____HR_____

Stand: BP_____HR_____

Frequency per week:
Exercise_____
Binging_____
Laxative Use_____
Vomiting _____

Patient Condition:
☐ Type1 diabetes ☐ Pregnant

Mandatory Attachments:
☐ Blood work ☐ ECG

☐ **PEPP – Prevention and Early Intervention Program for Psychosis**

- ☐ Suspected first episode of psychosis and no significant antipsychotic treatments provided yet
- ☐ Clients aged 16 – 35 years
- ☐ No methamphetamine use in the last three (3) months

☐ **FEMAP – First Episode Mood Anxiety Program**

- ☐ Mood or anxiety complaint in the absence of prior long-term (viz., 18 months) treatment
- ☐ Clients aged 16 – 25 years
- ☐ Less than 18 months lifetime psychiatric medication use (excepting psychostimulants)
- ☐ No developmental delay or substantial learning disability (i.e. needed an IEP due to learning problems in school)
- ☐ No traumatic brain injury

☐ **CDP – Concurrent Disorders Program**

The address is in London-Middlesex Y / N

Has a suspect or confirmed substance use disorder, gambling disorder, or other addiction Y / N

Has a suspect or confirmed major mental illness Y / N

Has an existing psychiatrist or care team Y / N

Is supported by a community addictions services Y / N

Presenting Symptoms *Check all that apply and provide details below

Primary diagnosis, if known: _____

☐ Depressed Mood ☐ Mania/Hypomania ☐ Anxiety/Panic ☐ Post-traumatic stress ☐ Psychosomatic Symptoms

☐ Gender Dysphoria ☐ Disruptive/Impulse Control Concerns ☐ Personality Disorder Symptoms ☐ OCD ☐ ADHD

☐ Psychotic Symptoms ☐ Eating Disorder ☐ History of violence/aggression

☐ Current substance abuse, specify: _____

☐ Please Provide Details: _____

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Current Safety Risk Factors (Assess and check all that apply)

☐ Active suicidal thoughts ☐ Passive suicidal thoughts ☐ History of suicide attempt(s)

☐ Thought to harm others ☐ History of violence/aggression ☐ Current intentional self-harm behaviours

☐ Behaviour influenced by delusions/command hallucinations ☐ Other, **please** specify:

Previous Mental Health Treatment / Hospitalizations

(Attach psychiatric and diagnostic history, including consult/progress notes, admission notes, discharge summaries, etc.)

☐ It is mandatory to send the list of all current and previous medication trials otherwise referral will be returned

☐ See attachments ☐ See Clinical Connect

Relevant Medical / Developmental History (i.e. developmental delay, epilepsy, dementia, acquired brain injury, etc.)

Psychosocial / Other Issues

☐ Marital/custody ☐ Sexual abuse ☐ Emotional abuse ☐ Financial issues ☐ Housing

☐ Work/school problems ☐ Anger/temper ☐ Grief/traumatic loss ☐ Charges pending ☐ On trial/incarcerated

Was this referral discussed with the client? ☐ Yes ☐ No **Is the client willing to accept services?** ☐ Yes ☐ No

Client Name:

Referring Source Information

Name:_____Billing #:_____

Phone #:_____Fax #: _____

Office Address:

City:_____Postal Code: _____

☐ Family Physician/NP ☐ Walk-In Clinic

☐ Other:_____

Does the client have a current Psychiatrist? ☐ Yes ☐ No

Psychiatrist Name: _____

REFERRING SOURCE SIGNATURE: _____ **DATE:** _____

If you have any inquiries or require clarification regarding this referral form, please contact the Centralized Access Point (CAP), Ambulatory Mental Health and Addictions Program at LHSC (519-685-8500 ext 76777) during business hours (Monday through Friday from 8:30 a.m. – 4:30 p.m., excluding holidays).

To submit this referral, send the completed referral form and relevant attachments to the Centralized Access Point Office at LHSC
FAX: 519-667-6685