ADULT MENTAL HEALTH AMBULATORY CENTRALIZED ACCESS POINT REFERRAL – LHSC AND ST JOSEPH'S

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

Please note: Our service is not able to provide immediate support in an emergency. **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.**

We are unable to provide the following services: disability follow-up appointments as part of EI/CPP/WSIB/ODSP requirements; Independent Medical Evaluations for Court and CAS Assessment; Forensics or Capacity assessments. A consult will be provided for all patients prior to any group linkage, unless there is a psychiatrist already involved in care.

PIN if available _____

Client Information

Last Name:_____

First Name:_____

Preferred Name: _____ DOB:_____

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

Referring Source Information

Name: _____ Billing #:_____

Phone #: _____ Fax #: _____

Office Address:

City: _____ Postal Code: _____

☐ Family Physician/NP ☐ Walk-In Clinic

☐ Community Agency ☐ Other: _____

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

Psychiatrist Name: _____

MRP: _____

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

☐ Active suicidal thoughts ☐ Passive suicidal thoughts ☐ History of suicide attempt

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

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

☐ **Request for General Adult Urgent Psychiatric Consultation Service**

Reason for Referral and Goals for Treatment

Brief description:

Primary diagnosis, if known:_____

Presenting Symptoms *Check all that apply and provide details above

☐ Mood ☐ Anxiety ☐ Post-traumatic stress ☐ Panic attacks

☐ Unusual speech/behaviour ☐ Delusions ☐ Fear/paranoia ☐ Negative symptoms

☐ Obsessions/compulsions ☐ Hallucinations ☐ Thought control ☐ Phobias, specify: _____

☐ Other: _____ ☐ Current substance abuse, specify:_____

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Client Name:

Optional Request for Specialized Program (Please ensure information <90 days old)

☐ **Adult Eating Disorders Service**

Ht:_____ Wt:_____ Temp. _____

Lay: BP_____ HR_____

Stand: BP_____ HR_____

Frequency per week:
Exercise _____ Binging _____
Laxative Use _____ Vomiting _____

Patient Condition:
☐ Refusal to eat ☐ Type1 diabetes
☐ Pregnant ☐ >4kg lost in past month

Mandatory Attachments:
☐ Blood work ☐ ECG

☐ **PEPP – Prevention and Early Intervention Program for Psychosis**
***Clients 16 – 35 years old**

☐ **Prospect Prodromal Clinic**

☐ Client willing and able to attend regular appointments in London?

☐ Methamphetamine use in last 3 months?

☐ **FEMAP – First Episode Mood Anxiety Program (research funded)**
***Clients 16 – 25 years old**

☐ Client willing and able to attend regular appointments in London?

☐ Client willing to participate in research?

Mandatory Attachment:
☐ Complete medication history

☐ **Transcultural Mental Health Consultation Service**
If referral is for a family: # of adults_____ # of children_____

Previous Mental Health Treatment / Hospitalizations

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

☐ See attachments ☐ See Clinical Connect

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

☐ Acquired brain injury

All Current Medications (Please provide a complete medication list below or as an attachment)

Medication	Dose (include units)	Frequency	Date prescribed

☐ See attached medication list

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

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

Please click "Submit Form" to submit this referral electronically or send completed referral and relevant attachments to the Centralized Access Point Office at LHSC fax: 519-667-6685

SUBMIT FORM

Centralized Access Point Office Use Only

Routing destination:	Routed by: