



WOMEN'S COLLEGE HOSPITAL
Health care for women | REVOLUTIONIZED

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MENTAL HEALTH REFERRAL FORM

PATIENT INFORMATION

(Affix Patient Label/Identification Here)

Name: _____ DOB: ____ / ____ / ____

YYYY/MM/DD

Gender: ____ Email address: _____

Health card: _____ Version code: _____

Full address: _____

Telephone: _____ Alternate #: _____

Previous management:

Is this patient currently receiving Mental Health services or treatment? Yes No
Received treatment in the last 6 months? Yes No If yes; what treatment & where? _____

Recent psychiatric hospitalization? Yes No (If yes, please attach discharge summary)

Comment/What treatment? _____

Emergency visit within the last 6 months for psychiatric care? Yes No

If yes, what treatment? _____

Exclusion criteria:

- Psychiatric emergency
- Pediatric patients under 18 years of age (excluding Child and Family Psychiatry Program)

CLINICAL INFORMATION /FINDINGS:

Past and current psychiatric history (Yes/No):

	Current	Past		Current	Past
Major depressive disorder			Alcohol/Substance dependence		
Bipolar affective disorder			Suicidal ideation		
Anxiety disorder			Suicidal attempts		
Obsessive compulsive disorder			Self harm		
Post-traumatic stress disorder			Aggressive behavior		
Psychosis			History of childhood trauma		
Eating disorder			Other		

Referral for child/family psychiatry consultation

- Are there safety concerns and/or Children's Aid Society involvement? Yes No
- Is there legal custody documentation? Yes No/pending In dispute N/A
- Are both parents aware of and in agreement with this referral? Yes No
- Parents' marital status: married common-law separated divorced

Current/relevant medical conditions:

Medications (current/past):

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