WCHH
WOMEN'S COLLEGE HOSPITAL
Healthcare | REVOLUTIONIZED

76 Grenville Street
Toronto, Ontario
M5S 1B2
Tel: 416-323-6230 Fax: 416-323-6356

MENTAL HEALTH REFERRAL FORM

PATIENT INFORMATION
(Affix Patient Label/Identification Here)

Name: _____ DOB: ___/___/____
DD/MM/YYYY
Gender: ____ Email address: _____
Health card: _____ Version code: _____
Full address: _____
Telephone: _____ Alternate #: _____

SELECT ONE CLINIC TYPE:

General Psychiatry
- ❑ Day Treatment Program
- ❑ General Psychiatry
- ❑ Mental Health in Medicine
- ❑ Substance Use Service
- ❑ Other:_____

Referral Date: ____/____/_____
DD / MM / YYYY

Reproductive Life Stages Program (RLS)
- ❑ Child and Family Psychiatry
- ❑ Reproductive Life Stages (RLS)

Trauma Therapy Program
❑ Trauma Therapy Program ❑ 1st referral ❑ Re-referral

ADDITIONAL PATIENT INFORMATION

Preferred name:

Gender: Pronouns: ❑ He/Him ❑ She/Her ❑ They/Them ❑ Other

Language spoken: Interpreter required: ❑ Yes ❑ No

Allergies:

REFERRING PROVIDER INFORMATION

Name:
Address:
Telephone:
Fax:
Billing #: _____
Signature: _____

Primary Care Provider (required):
(Name, Telephone & Fax #)
Billing #: _____

Is Primary Care Provider aware of this referral? ❑ Yes ❑ No

Alternate report sent to:

REASON FOR REFERRAL

Chief psychiatric complaint/clinical question:

For General Psychiatry
- ❑ Diagnostic clarification
- ❑ Medication recommendations
- ❑ Psychotherapy recommendations

Is the mental health concern associated with a medical condition?
❑ Yes ❑ No
If yes, please describe_____
_____

For RLS Only
- ❑ Preconception planning
- ❑ Pregnancy (Expected date of delivery)
  DD / MM / YYYY _____/____/_____
  Hospital or place of delivery
  _____
- ❑ Postpartum (Actual date of delivery)
  DD / MM / YYYY _____/____/_____
  Hospital or place of delivery
  _____
- ❑ Premenstrual
- ❑ Perimenopausal
- ❑ Other: _____

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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):