WCHI
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

SELECT ONE CLINIC TYPE:

General Psychiatry & Mental Health in Medicine Program

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

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

PATIENT INFORMATION
(Affix Patient Label/Identification Here)

Name: _____ DOB: ___/___/____
DD/MM/YYYY

Gender: ____ Email address: _____

Health card: _____ Version code: _____

Full address: _____

Telephone: _____ Alternate #: _____

Reproductive Life Stages Program (RLS)

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

Trauma Therapy Program

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

Women Recovering from Abuse Program (self referral)

Brief Psychotherapy Centre for Women (self referral)

ADDITIONAL PATIENT INFORMATION

Language spoken:	Interpreter required: ❑ Yes ❑ No
Allergies:	Gender:

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 RLS Only

- ❑ Preconception planning
- ❑ Pregnancy (Expected date of delivery)
  DD / MM / YYYY _____/____/_____
- ❑ Postpartum (Actual date of delivery)
  DD / MM / YYYY _____/____/_____
- ❑ Premenstrual
- ❑ Perimenopausal
- ❑ Other: _____

For General Psychiatry & Mental Health in Medicine

- ❑ Psychiatric consultation for diagnosis/treatment
- ❑ Time-limited medication management assessment
- ❑ Time-limited psychotherapy assessment
- ❑ Time-limited medication management & psychotherapy assessment
- ❑ Other: _____

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 #: _____

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?
- Are both parents aware of and in agreement with this referral? ❑ Yes ❑ No/pending ❑ In dispute ❑ N/A
  ❑ Yes ❑ No
- Parents' marital status: ❑ married ❑ common-law ❑ separated ❑ divorced

Current/relevant medical conditions:

Medications (current/past):