



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**

- Day Treatment Program
- General Psychiatry
- Mental Health in Medicine
- Substance Use Service
- Other: \_\_\_\_\_

**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

**REFERRAL DATE:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
DD / MM / YYYY

**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: \_\_\_\_\_ Billing #: \_\_\_\_\_

Address: \_\_\_\_\_ Signature: \_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

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

Is Primary Care Provider aware of this referral?  Yes  No

Alternate report sent to: \_\_\_\_\_ DD / MM / YYYY

**REASON FOR REFERRAL**

<p><b>Chief psychiatric complaint/clinical question:</b></p>   <p><b>For General Psychiatry</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Diagnostic clarification</li> <li><input type="checkbox"/> Medication recommendations</li> <li><input type="checkbox"/> Psychotherapy recommendations</li> </ul> <p>Is the mental health concern associated with a medical condition? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please describe _____</p>	<p><b>For RLS Only</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Preconception planning</li> <li><input type="checkbox"/> Pregnancy (Expected date of delivery) DD / MM / YYYY ____/____/____ Hospital or place of delivery : _____</li> <li>EPDS Score: _____</li> <li><input type="checkbox"/> Postpartum (Actual date of delivery) DD / MM / YYYY ____/____/____ Hospital or place of delivery : _____</li> <li>EPDS Score: _____</li> <li><input type="checkbox"/> Premenstrual</li> <li><input type="checkbox"/> Perimenopausal</li> </ul> <p><b>EPDS Form:</b> <a href="https://www.womenscollegehospital.ca/care-programs/mental-health/">https://www.womenscollegehospital.ca/care-programs/mental-health/</a></p>
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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):**

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