WCH

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

REFERRAL DATE: ____/____/______
DD / MM / YYYY

PATIENT INFORMATION
(Affix Patient Label/Identification Here)

MRN:____________ HCN:__________________________

Name:______________________________________

Sex:__________ Date of Birth:______/_____/______
DD / MM / YYYY

Address:____________________________________

Telephone:______________ Alternate #:______________

ADDITIONAL PATIENT INFORMATION

Preferred name: Gender (*if not same as above*):

Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ __________________

Other insurance coverage (IFH, UHIP, etc.): ☐ Self-pay

Language spoken: Interpreter required: ☐ Yes ☐ No

Patient is aware of and in agreement with this referral: ☐ Yes ☐ No

A confidential message can be left when contacting the patient: ☐ Yes ☐ No

REFERRING PROVIDER INFORMATION

Name:
Address:
Telephone:
Fax:

Billing #: ____________________________

Signature: ____________________________

❑ Referring Provider is not the Primary Care Provider
Primary Care Provider Name: ______________________________ Phone:____________ Fax:____________
Primary Care Provider is aware of this referral: ☐ Yes ☐ No

REASON FOR REFERRAL

Clinic Type:

☐ **General Psychiatry**
○ Diagnostic clarification ○ Medication recommendations ○ Psychotherapy recommendations
Is the mental health concern associated with a medical condition? ○ No ○ Yes:____________________________

☐ **Day Treatment Program**
Client goals for referral: ____

☐ **Seeking Safety Group**
○ Referring MD agrees to follow the patient for the duration
Substance use history:____
Patient acknowledges history of interpersonal trauma ○ No ○ Yes ....○ Childhood ○ Adult
Symptoms of post-traumatic stress disorder:______________________________________

☐ **Trauma Therapy Program**
History of childhood trauma (physical/sexual/emotional abuse/neglect) prior to age eighteen
○ No ○ Yes:____

☐ **Reproductive Life Stages**
○ Pregnancy planning
○ Premenstrual dysphoric disorder (PMDD)
○ Perimenopausal
○ Pregnancy...................(due date dd/mm/yyyy)___/___/______ Hospital of delivery:______________________
○ Postpartum..........(delivery date dd/mm/yyyy)___/___/______ Hospital of delivery: ______________________
(Required for pregnancy and postpartum) Edinburgh Perinatal/Postnatal Depression Score: __________

Fax Disclaimer: This fax transmission contains confidential information that is intended only for the Women's College Hospital Clinics. If you are not the intended recipient, you are hereby notified that any disclosure, copying or distribution of the contents of this fax is strictly prohibited. If you have received this fax transmission in error, please immediately notify the referring health practitioner at the telephone number provided above to arrange for the return or destruction of this document.

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)

MRN:____________ HCN:______________________

Name:______________________________________

Sex:__________ Date of Birth:_____/_____/_____
DD / MM / YYYY

Address:____________________________________

Telephone:______________ Alternate #:____________

REASON FOR REFERRAL

Chief psychiatric complaint/clinical question:

PSYCHIATRIC HISTORY

Please attach all collateral notes/discharge summaries related to previous management and hospitalization(s).

Previous Management
Is the patient currently receiving mental health services or treatment? ○ No ○ Yes
Have they received treatment in the last 6 months? ○ No ○ Yes
If yes, what treatment & where: ______________________________

Recent psychiatric hospitalization? ○ No ○ Yes
If yes, what treatment?______________________________

Emergency visit within the last 6 months? ○ No ○ Yes
If yes, what treatment?______________________________

Exclusion criteria:
- **Psychiatric emergency**
- **Pediatric patients under 18 years of age**

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		

ADDITIONAL CLINICAL INFORMATION

Past and current medical history:

Allergies and reaction:

Current medications (include list):

Fax Disclaimer: This fax transmission contains confidential information that is intended only for the Women's College Hospital Clinics. If you are not the intended recipient, you are hereby notified that any disclosure, copying or distribution of the contents of this fax is strictly prohibited. If you have received this fax transmission in error, please immediately notify the referring health practitioner at the telephone number provided above to arrange for the return or destruction of this document.