ST JOSEPH'S HEALTH CENTRE TORONTO

Outpatient Mental Health Collaborative Care Clinic Referral Form

Fax to: 416-530-6774

5th Floor Morrow Wing
30 The Queensway, Toronto, Ontario M6R1B5
Tel: 416-530-6717

CATCHMENT AREA:

Please only refer clients who live in the following postal codes:

M6E, M6H, M6K, M6M, M6N M6P, M6R, M6S, M8V, M8X, M8Y, M8Z, M9A

IMPORTANT: Please read the attached CCC FAQ Sheet to get more information on what services we offer and our exclusion criteria. Referrals may not be processed under certain conditions. We DO NOT provide urgent consultations. Clients will be contacted directly with an appointment.

Date of Referral

Client information:

Surname	First Name	SJHC Medical Record # (if available)	
Telephone: Alternate Telephone (e.g., cell):		OHIP and Version Code	
Address	Postal code (required)	Interpreter Required? ☐ No ☐ Yes	Language:
Gender:	Marital status:	Permission to leave voicemail? ☐ Yes ☐ No	
Date of birth		Permission to speak with family member/roommate? ☐ Yes ☐ No	
Some of our psychiatrists send out a link to a password protected questionnaire that will improve the quality of the assessment. Would client be willing to receive this by: ☐ cell phone ☐ email: _____Or ☐ Declined			

Referral source information:

Name of Primary Care Provider	
PCP Phone number	
PCP Fax number	
Organization/clinic	
Billing number	

Please indicate any current or pending: (please note we do not manage 3rd party claims and documentation)

☐ Community Treatment Order	☐ Insurance Claim	☐ CAS Involvement
☐ WSIB Claim	☐ Disability or Pension Claim	☐ Court/Legal proceedings

Please specify the client population:

☐ Adult Psychiatry (age 18-64) ☐ Psychogeriatric (age ≥65) ☐ Perinatal

For office use only:	
Date Referral Received:	Date (s) Attempted to Contact Client:
Clinician or Physician Assigned:	Date of Intake Appointment:
Date Triaged:	

Please choose ONE referral stream from the two options below and indicate the goals/reasons for consultation:

☐ **Collaborative Care Consultation:**	**OR**	☐ **Psychopharmacology Consultation:**
Comprehensive psychiatric consultations for adults that include detailed treatment. **Short term** follow-up may be offered and we require that the client's Primary Care Provider (PCP) remain active in their client's care. When clients have completed their episode of care in our clinic, they are discharged back to the PCP.		Offered after PCP has initiated medication treatment that has not been effective and client is seeking medication-based treatment only. Client will be seen for a **maximum of two appointments** followed by a written report with treatment recommendations.

MANDATORY: Reason for consultation - please indicate client's goal for the consultation and check a box below if applicable:

☐ Treatment recommendations	☐ Patient is on, or needs to be on, medication that you do not start on a regular basis
☐ Diagnostic clarification	☐ Patient has a psychiatric condition that you rarely see in practice
☐ Episode of care follow-up	☐ Patient is treatment refractory

Please indicate past history of: (**mandatory: please specify and attach any relevant documents)**

Self-Harm/Suicidality	☐ No ☐ Yes:
Violence or Aggressive Behaviour	☐ No ☐ Yes:
Substance use	☐ No ☐ Yes:
Cognitive impairment	☐ No ☐ Yes:
Criminal Charges	☐ No ☐ Yes:

List of all current psychiatric and non-psychiatric medication: (please attach list of all agents and doses used in the past)

Medication	**Dose**	**Frequency**	**When Prescribed** (DD/MM/YY)

Psychiatric/Medical History: (mandatory: please attach all relevant documentation)

Previous Psychiatric Diagnosis	☐No ☐Yes (please specify):
Past hospitalizations and/or psychiatric treatment	☐No ☐Yes (please specify):
Medical Diagnoses/Problems (including investigations in progress)	☐No ☐Yes (please specify):
Allergies	☐No ☐Yes (please specify):
Current Case Manager, Counselor or Therapist	☐No ☐Yes **If yes, please give name, agency and phone number of worker:**

☐ I acknowledge that I have provided the most recent and accurate information required for this referral, and will collaborate with us during treatment and continue care of my patient upon discharge from the program.

Date: **Name:** _____