



ADULT REFERRAL

Client Patient: _____
(Last Name, First Name)

Health Record #: _____

Please print clearly and include any relevant lab results (especially drug levels), medical reports, medication sheet, psychological reports, and copies of previous psychiatric consultations or discharge summaries, along with Disclosure of Health Information Form.

Note: The following CAMH Services DO NOT require this referral form to be completed by a physician:
- Addictions - Schizophrenia - Dual Diagnosis

Date of Referral: _____
(dd/mm/yyyy)

Client/Patient Information	Referring Source Information
Name:	Name:
Phone Number: Home: Office: Can a confidential message be left on the client/patient's voicemail? <input type="checkbox"/> Yes <input type="checkbox"/> No Can a confidential message be left with family? <input type="checkbox"/> Yes <input type="checkbox"/> No	Phone Number: Fax Number:
Address: If it is not acceptable to send an appointment letter to this address, specify how the client/patient prefers to be contacted.	Address:
Health Card #: _____ - _____	Billing Number: _____ - _____
Date of Birth: ___/___/___ (dd/mm/yyyy)	Check one: <input type="checkbox"/> Family Physician <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other (specify) _____
Age: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Check if former client/patient of CAMH <input type="checkbox"/>	
If Applicable: Name of Next of Kin/Guardian: _____ Relationship to client/patient: _____ Address: _____ Tel: _____	Name of Psychiatrist: _____ Is client/patient's current psychiatrist aware of referral? No <input type="checkbox"/> Yes <input type="checkbox"/> Does not have a psychiatrist <input type="checkbox"/> (We request that you attach Consent to Release of Personal Health Information Form and assessment report/letter from this psychiatrist prior to sending referral.)
Is there a need for an interpreter (e.g., for sign language or other language)? No <input type="checkbox"/> Yes <input type="checkbox"/> (please specify):	
Are there any other barriers to communication with this client/patient? No <input type="checkbox"/> Yes <input type="checkbox"/> (please specify):	

ADULT REFERRAL



Addressograph /
Patient ID Label (Bar Code)

Client Patient: _____
(Last Name, First Name)
Health Record #: _____

1. REASON FOR REFERRAL

Reason(s) for requesting this consultation *(please be specific)*:

Is your client/patient (or substitute decision maker) aware of and in agreement with the referral and that he/she will be seen for a consultation? *(Check one)*: Yes No *(If no, please explain)*: _____

2. CURRENT PSYCHIATRIC PRESENTATION:

3. CURRENT WORKING DIAGNOSIS *(Space on last page to provide additional information)*

CURRENT WORKING DIAGNOSIS /DIAGNOSES	CHECK ALL THAT APPLY	WHICH IS PRIMARY PLEASE CHECK <input checked="" type="checkbox"/> BOX	DESCRIBE CURRENT SPECIFIC SIGNS AND SYMPTOMS:	PAST HISTORY? PLEASE CHECK <input checked="" type="checkbox"/> BOX												
Depression			Actively Suicidal <input type="checkbox"/> Hallucinations <input type="checkbox"/> Delusions <input type="checkbox"/>													
Bipolar			Mania <input type="checkbox"/> Depression <input type="checkbox"/> Mixed Episode <input type="checkbox"/> With hallucinations <input type="checkbox"/> Delusions <input type="checkbox"/>													
Anxiety			Social <input type="checkbox"/> Panic <input type="checkbox"/> OCD <input type="checkbox"/> Generalized <input type="checkbox"/> PTSD <input type="checkbox"/>													
Schizophrenia / Psychotic Disorder			Hallucinations <input type="checkbox"/> Delusions <input type="checkbox"/>													
Intellectual Disability			Suspected <input type="checkbox"/> Confirmed <input type="checkbox"/> Confirmation requested <input type="checkbox"/>													
Dual Diagnosis			Please specify level of intellectual disability [MR] as diagnosed by a licensed psychologist: Mild MR <input type="checkbox"/> Moderate MR <input type="checkbox"/> Severe MR <input type="checkbox"/> MR Not Specified <input type="checkbox"/>													
Dementia																
Delirium																
Substance Use			Is the individual expressing interest in addressing his/her current substance abuse problem? <i>(Check one)</i> <input type="checkbox"/> No <input type="checkbox"/> Yes <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 33%;">Substance</th> <th style="width: 33%;">Amount</th> <th style="width: 33%;">Frequency</th> </tr> </thead> <tbody> <tr> <td style="border: 1px solid black; height: 20px;"></td> <td style="border: 1px solid black; height: 20px;"></td> <td style="border: 1px solid black; height: 20px;"></td> </tr> <tr> <td style="border: 1px solid black; height: 20px;"></td> <td style="border: 1px solid black; height: 20px;"></td> <td style="border: 1px solid black; height: 20px;"></td> </tr> <tr> <td style="border: 1px solid black; height: 20px;"></td> <td style="border: 1px solid black; height: 20px;"></td> <td style="border: 1px solid black; height: 20px;"></td> </tr> </tbody> </table> <i>(Please use last page for additional information)</i>	Substance	Amount	Frequency										
Substance	Amount	Frequency														
Problem Gambling			Is the individual impacted negatively by their own or someone else's gambling? <input type="checkbox"/> No <input type="checkbox"/> Yes Does the individual want to address gambling-related concerns? <input type="checkbox"/> No <input type="checkbox"/> Yes													

If no working diagnosis, what is suspected? *(For example, diagnosis including developmental delay?)*

ADULT REFERRAL



Addressograph /
Patient ID Label (Bar Code)

Client Patient: _____
(Last Name, First Name)
Health Record #: _____

Is there any legal or forensic aspect to this referral?
 No Yes (*specify*): _____

Is the client/patient involved in current/pending compensation/insurance claims?
 No Yes (*specify*): _____
 (We do not accept referrals primarily dealing with compensation/insurance issues)

4. RISK ISSUES: Additional space provided on LAST PAGE

IS THERE ANY HISTORY OF EACH OF THE FOLLOWING?	NO	YES	IF YES: WHEN?	COMMENTS
Criminal charges				
Violent behaviour / Fire starting				
Suicidal Attempts				
Other self-harm behaviour				

5. CURRENT MEDICATIONS (Psychiatric and Non-Psychiatric)
Additional space provided on LAST PAGE or attach medication sheet

MEDICATION	DOSE / FREQUENCY	COMMENTS

6. PAST MEDICATIONS (Psychiatric and Non-Psychiatric)

MEDICATION	DOSE / DURATION	RESPONSE & ADVERSE EFFECTS

7. CURRENT and PAST PSYCHOTHERAPIES OR OTHER THERAPIES

THERAPY	WHEN / DURATION	OUTCOME/COMMENTS



ADULT REFERRAL

* D 0 2 4 2 B *

Addressograph /
Patient ID Label (Bar Code)

Client Patient: _____
(Last Name, First Name)

Health Record #: _____

8. RELEVANT MEDICAL HISTORY:

[Empty box for relevant medical history]

ADDITIONAL INFORMATION / NOTES

(e.g.: client/patient strengths, current and/or past medications; additional medical history; other comments)

[Empty box for additional information / notes]

Please complete the Referral Form and fax it back to the appropriate program:

Centralized Assessment, Triage and Support (CATS) - (416) 979-6815 or CATS Lakeshore Clinic (Etobicoke, Peel and surrounding area) - (416) 255-4556; Addictions - (416) 595-6619; Dual Diagnosis – (416) 504-1272; Dual Diagnosis Peel – (905) 568-4159; Geriatric Mental Health: (416) 583-1296; Law & Mental Health - (416) 583-4319; Mood & Anxiety - (416) 260-4208; Schizophrenia Continuing Care - (416) 583-1211; Schizophrenia First Episode – (416) 260-4197; Peel First Assessment Clinical Team - (905) 568-4159; Women’s Program - (416) 979-4975.

Completed by (Print Name): _____ Date (dd/mm/yyyy): _____

Signature and credentials: _____