William Osler Health System

Outpatient Mental Health (Centralized Intake and Triage)

REFERRAL FORM

Brampton Civic Hospital
Etobicoke General Hospital
Peel Memorial Centre
Community Mental Health Team
Phone: 905-494-6709
Fax: 905-494-6757

Patient Identification

Service Information

Referral Source ☐ ER/ UCC ☐ Acute Care ☐ Primary Health Care ☐ Other_____

William Osler Outpatient Mental Health offers short term psychiatric consultation, group psychotherapy, and limited short term individual psychotherapy for patients with mental health concerns. Services may be offered at the Brampton Civic Hospital, Etobicoke General Hospital, Peel Memorial Centre, or Queen Square Family Health Team's Community Mental Health Team.

INCLUSION CRITERIA

- Resides in Central West LHIN
- Provisional diagnosis of mental illness

EXCLUSION CRITERIA

- Actively suicidal or homicidal
- Requiring crisis assessment or hospital admission
- Assessments for court purposes or forensic psychiatry
- Completion of forms for insurance or medical purposes

Patient Information

Patient's Last Name: _____ **Patient's First Name:** _____

Date of Birth: (DD/MM/YY) _____ **Gender:** ☐ **Male** ☐ **Female** ☐ **Other**

Health Card Number: _____ **Version:** _____ **No OHIP:** ☐

Address: _____ **City:** _____ **Province:** _____ **Postal Code:** _____

Phone # (primary): _____ **Phone # (alternate):** _____ **Cell #:** _____

Patient's E-mail: _____ ☐ **Interpretation Services Required; Language:** _____

Person to contact for booking appointment ***(If different than patient):*** _____

Relationship to patient: _____

Can a message be left on the phone number provided? ☐ **Yes** ☐ **No**

If the patient is a child, who has parental custody/guardianship?_____

Reason for Referral & Relevant Patient History

URGENCY

☐ Urgent
☐ Routine (within 6 weeks)

AGE RANGE

☐ Child (<18) ☐ Adult

Reason for referral:

☐ Psychiatry Consult
☐ Mood & Anxiety Psychotherapy Program (Stepped Care Program)
☐ Psychosis Program (inc. Depot/Clozapine)
☐ Eating Disorders Clinic

Presenting Problem/Provisional Diagnosis:

_____

_____

_____

Current Medications:

_____

_____

Referring Physician/Nurse Practitioner (NP) Information

Referring Physician/NP Name: _____ **OHIP Billing Number:** _____

Phone #: _____ **Fax #:** _____ **E-mail:** _____

Family Physician/NP *(If different from above)***:** _____

Signature of Referring Physician/NP: _____ **Referral Date:** _____

Clinic Use Only

Date Referral Screened: _____
Date Appt. Booked: _____
Date of Appt.: _____

Referral Received Actions:

☐ Approved
☐ Patient Refused
☐ Redirected to _____
☐ Other _____