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 _____

William Osler Health System
Going Beyond

EATING DISORDERS CLINIC
Peel Memorial Centre for Integrated Health and Wellness
20 Lynch Street. 3rd Floor. Unit 3A Brampton, ON. L6W 2Z6
TEL: (905) 863- 2560; FAX: 905-863-2471

Eating Disorders Referral Form

BEFORE COMPLETING THIS REFERRAL FORM PLEASE READ:

 The Eating Disorders Program provides outpatient services for patients of all ages.

 For patients **under the age of 18**, we provide family based treatment and **require consent from the patient to communicate with the parent(s)/guardian(s).**

The patient, _____, gives consent for the Eating Disorders Program at William Osler Health System to communicate with the parent(s)/guardian(s) for the purposes of screening and booking appointments.

☐ YES (patient to sign and date): _____

☐ NO (provide reason): _____

Parent/Guardian Name(s) _____

 Referral to the program is for consultation and treatment recommendations. Treatment will be offered if appropriate. Treatment is time limited and focused on normalized eating and symptom reduction. This program is not suitable for everyone.

 A patient is appropriate for referral if he/she has an eating disorder and has a **Body Mass Index (BMI) of 16 or more**.

 We do not offer inpatient or day hospital treatment. If you believe your patient requires intensive treatment or could in the foreseeable future, please refer to www.ocoped.ca for a list of intensive services in Ontario.

 The Primary Health Care Provider is responsible for the medical monitoring of their patient while on the waiting list for service. Patients must be medically stable prior to referral and at the start of services within the program. The nurse practitioner in the clinic will monitor patients while in the program and communicate regularly with the Primary Health Care Provider, who is the main responsible provider**.**

Date of Referral: _____

Last Name: _____ **First Name:** _____

Date of Birth (D-M-Y): _____ **Age:** _____ **Sex:** _____

Health #: _____

Address: _____

City: _____ **Postal Code:** _____

Main Telephone: _____ **Other Telephone:** _____

Presenting Problem(s):

Current Measured Height: _____ Current Measured Weight: _____ BMI: _____
(Please include growth charts for ALL patients under the age of 18)

Weight History (Any changes in weight over time; rapid weight loss):

Weight Control Methods (Must complete all area below)

	No	Yes	# Per Day	# Per Week
Food Restriction	☐	☐		
Binging	☐	☐		
Induced Vomiting	☐	☐		
Laxatives	☐	☐		
Diet Pill/Substances	☐	☐		
Diuretics	☐	☐		
Excessive Exercise	☐	☐		

Associated Medical or Mental Health Issues:

Current Medications:

Physical Exam/Positive Findings:

Supine HR: _____BP:_____ Standing HR: _____BP:_____

Menstrual status and regularity. _____

Please complete and evaluate your patient's current status on the following tests. Please note that the results should be *no older than two weeks*.

ECG with report	Phosphate	AST , ALT , GGT	Albumin
CBC & Diff	Glucose	Amylase, Lipase	Vitamin B12
Electrolytes	BUN	Gonadotropins & sex steroids	TSH
Calcium	Creatinine	Bicarbonate, Chloride	Ferritin
Magnesium	Lipids (if binging)	Growth charts	ESR

Referring Health Care Provider

Name: _____

Address: _____

Telephone: _____

Fax: _____

Primary Health Care Provider

Name: _____

Address: _____

Telephone: _____

Fax: _____

Does patient give consent for the William Osler Eating Disorders Program to speak to Primary Health Care Provider if not referring?

☐ Yes ☐ No

Thank you for your referral. Our staff will contact your patient directly for a telephone screening appointment. If you require any further information please do not hesitate to contact us.