ST. JOSEPH'S UNITY HEALTH TORONTO

Caring hearts. Leading minds.

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

See the Program Information Sheet for additional detail on available services and exclusion criteria. Please attach relevant medical documentation to avoid delays in processing your referral.

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 and pronouns:	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 specify the client population:

☐ Adult Psychiatry (age 18-64) ☐ Psychogeriatric (age ≥65) ☐ Perinatal (if the client is currently pregnant, please indicate where they are planning on delivering: _____)

MANDATORY: Reason for consultation - please indicate client's goal for the consultation

Please indicate any current or pending: (please note we do not manage 3rd party claims and documentation, nor complete parenting assessments.)

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

Please indicate current/history of:

Self-Harm Behaviour	☐No ☐Yes (please specify):
Suicidal Actions/Attempts	☐No ☐Yes (please specify):
Violent Behaviour	☐No ☐Yes (please specify):
Criminal Charges	☐No ☐Yes (please specify):

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):
Previous psychotherapy? If so, which modality?	☐No ☐Yes (please specify):
Active substance use (previous 90 days)?	☐No ☐Yes (please specify):
History of substance use disorder?	☐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.

☐ I acknowledge that I will remain the Most Responsible Practitioner or 'MRP', with overall responsibility for directing and coordinating the referred patient's care. If I discharge the patient from my practice before or during their episode of care in the Collaborative Care Clinic I will connect the patient to a different primary care provider who will take over their care.

Date: **Signature:** _____