ST. MICHAEL'S
UNITY HEALTH TORONTO

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Unity Health Toronto – St. Michael's
30 Bond Street, 17 Cardinal Carter South
Toronto, ON M5B 1W8
Phone: 416-864-5120
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Ambulatory Mental Health and Addictions Service (MHAS) Referral

CATCHMENT FOR SERVICES

- **East of Yonge St.**
- **West of Victoria Park Ave.**
- **North of Lake Ontario**
- **South of Bloor St.**

REFERRING PHYSICIAN'S INFORMATION:		
Physician's Name:	OHIP Billing #:	
Address:		Postal Code:
Tel:	Fax:	Email:
Specialty (specify):	Family Physician (if different):	

PATIENT INFORMATION:

Lives in catchment area (see above) ☐ Patient consents to referral ☐

Reasons for non-catchment referral: _____ Requires Interpretation Services **Y** ☐ **N** ☐

Language:_____

Last Name:	First name:	MRN(if available):	
Address:			
Postal Code:	Tel:	Mobile:	Gender:
DOB (MM/DD/YY)	Health Card Number:		Version Code:

Consent to leave message: Voicemail **Y** ☐ **N** ☐ With another person: **Y** ☐ **N** ☐

PLEASE CHECK BOXES TO INDICATE REFERRAL MEETS THE FOLLOWING CRITERIA:

- ☐ Patient informed services are time-limited
- ☐ Referral is not from a hospital that has psychiatric services (unless patient in SMH catchment)
- ☐ Patient does not have psychiatrist, or if patient does, referral is with the psychiatrist's knowledge
- ☐ Assessment is not being requested for a legal or compensation matter – e.g. court, CAS, WSIB, insurance, etc.
- ☐ Referring physician agrees to accept patient back once psychiatric care is complete

SELECT MENTAL HEALTH SERVICE REQUESTED (CHOOSE ONE ONLY):

Mental Health Assessment Clinic (General Psychiatry):

☐ Consultation only ☐ For consultation and short-term follow-up

Sub-specialty Mental Health Assessment:

☐ Mood Disorders	Complex mood patients who have received previous psychiatric care
☐ Medical Psychiatry Attach extra page if required	Please identify medical condition(s): _____ If HIV please indicate CD4:_____ Viral Load:_____ SMH subspecialists providing ongoing care: _____
☐ Neuropsychiatry and Brain Injury	Please include relevant consultation/imaging reports
☐ Concurrent Disorders	Referral for non-urgent assessments *RAC drop-in for urgent cases
☐ Geriatric Psychiatry	Mental health assessment for patients ages 65+
☐ Memory Clinic	MoCA score:_____ MMSE:_____ Please include CT, MRI, SPECT reports
☐ Child Psychiatry	Mental health assessment for children ages 5 to 17

REASON FOR REFERRAL:

ADDITIONAL INFORMATION:

Past Psychiatric History (please include most recent consultation, discharge summary or notes):

Past Psychiatric Medication Trials:

Date Medication Dose Outcome

Past Medical History (please include relevant reports or attach patient profile summary):

CURRENT MEDICATIONS (List ALL medications including DOSE and FREQUENCY):

Allergies:

RISK ISSUES	PRESENT		PAST		DETAILS
	Y	N	Y	N	
Forensic Charges					
Violent Behaviour					
Suicide Attempts					
Substance Use					
Other Self Harm Behaviour					

AGENCIES, MENTAL HEALTH THERAPIES OR HOSPITALIZATIONS FROM THE LAST TWO YEARS:

Signature: _____ Date of referral: _____

Name (print): _____ Designation: _____

PLEASE NOTE THAT FORMS THAT ARE INCOMPLETE WILL BE RETURNED

Reset Form