ST. MICHAEL'S
UNITY HEALTH TORONTO

Unity Health Toronto – St. Michael's
30 Bond Street, 17 Cardinal Carter South
Toronto, ON M5B 1W8
Phone: 416-864-5120
Fax: 416-864-5480

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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 Identity: | Pronouns: |
| DOB (MM/DD/YY) | Health Card Number: | Version Code: | |
| Consent to e-mail communication: ☐ **Y** ☐ **N** | Consent to 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:**

| | |
|---|---|
| ☐ Medical Psychiatry<br>Attach extra page if required | SMH subspecialists providing ongoing care: _____<br>Please identify medical condition(s): _____<br>If HIV please indicate CD4:_____ Viral Load:_____ |
| ☐ Pathways | Referral for non-urgent assessment of concurrent mental health and substance use disorders **RAAM drop-in available for urgent substance use disorders care* |
| ☐ Geriatric Psychiatry | Mental health assessment for patients ages 65+ |
| ☐ Memory Clinic | MoCA score:_____ MMSE:_____<br>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