ST. JOSEPH'S UNITY HEALTH TORONTO

Recovery and Reintegration Program Referral Form

CATCHMENT FOR SERVICES

M6E, M6H, M6K, M6M, M6N, M6P, M6R, M6S, M8V, M8W, M8X, M8Y, M8Z, M9A, M9B, M9C

PLEASE FAX TO
St. Joseph's Health Centre
30 The Queensway
Toronto, ON M6R 1B5
Phone: 416-530-6000 ext. 4519
Fax: 416-530-6774

NOTE: If the patient does not have access to a physician or nurse practitioner to complete this referral but wishes to access our program, please contact us directly.

REFERRAL SOURCE INFORMATION		
Name:		Referring Physician OHIP Billing #:
Address:		Postal Code:
Phone:	Fax:	Email:
Specialty:		Family Physician (if different):
PATIENT INFORMATION		
Patient lives in catchment area (see above): ☐		Patient consents to referral: ☐
Patient requires interpretation services: Yes ☐ No ☐ Language:		Health Card Number and Version Code:
Last Name:		First Name:
Address:		Postal Code:
Date of Birth (MM/DD/YYYY):		Gender Pronouns:
Phone:		Alternate Phone:
Patient consents to receive voicemails: Yes ☐ No ☐		
ALTERNATE CONTACT INFORMATION		
If the patient does not have a phone or is difficult to reach, is there someone with whom they are in regular contact that we can reach out to?		
Last Name:		First Name:
Phone:		Relationship to Patient:
Has the patient consented for us to contact this person? Yes ☐ No ☐		Has the patient consented for us to leave voicemails with this person? Yes ☐ No ☐

REASON FOR REFERRAL	PROGRAM CRITERIA
	Eligibility Criteria: • Aged 18-29 years • Experiencing psychosis or have a primary diagnosis of a psychotic disorder

MENTAL HEALTH HISTORY (i.e., symptoms, diagnoses, treatment history, hospitalizations, substance use history)

SAFETY RISKS (i.e., history of violent behaviours, suicide attempts, or other self-harm behaviours)

SERVICES, AGENCIES, OR COMMUNITY SUPPORTS ALREADY INVOLVED

*****IF AVAILABLE, PLEASE ATTACH RELEVANT DOCUMENTATION (e.g., assessment/consultation reports, medical records, hospital discharge summaries, medication lists)*****

Name (please print) | Designation

Signature | Date of referral