

Markham Stouffville Hospital Corporation

381 Church St.
Markham Ontario
L3P 7P3

Bridge Referral Form

Name: _____ Date of Birth: _____ Date of Referral: _____

Address: _____ Language: _____
Name of Attending Psychiatrist: _____

Home telephone number _____ Can a message be left at this number? Yes No

Cell phone number _____

Referral Source: Psychiatrist office OPMH Clinic 1 West

Reasons for Referral: Learn coping strategies Stress Management Social Skills

Structure/routine Other: (please specify) _____

Psychiatrist recommended length of stay: 1 -2 weeks 1 month

2 months 3 months

Diagnosis: _____

Current medications (please state the dosage and frequency) _____

Current stressors: _____

Has patient been referred to any external community agencies? Yes No

Name of contact/agency

Telephone number

Patient's source of income Please check () which box applies

Savings Employment Insurance Short term disability Insurance

Long term disability Insurance Ontario Works Family

Ontario Dissability Support Program Other _____

Employed Occupation _____

Does patient have private insurance coverage? Yes No If yes, please name the insurance company: _____

Does the patient's employer have an Employment Assistance Program? Yes No

Has the patient used this service? Yes No (Please give details) _____

Are there any cultural practices that we should be aware of regarding the care of this patient? (please specify) _____

Reason for non-admission to the program: _____

Date of Admission: _____ Assessed By: _____

Date of Initial Contact: _____

