

NOTE: Incomplete and/or unsigned requisitions will be returned

PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

MARKHAM STOUFFVILLE HOSPITAL CORPORATION

**OUTPATIENT MENTAL HEALTH REFERRAL
(External)**

Adult OPMH Telephone: (905) 472-7011
Child & Adolescent OPMH Telephone: (905) 472-7530

Please Fax To: (905) 472-7371

Patient will be contacted once a completed referral has been received.
Treatment approach and duration are at the discretion of the
OPMH clinicians and psychiatrists.

- Adult OPMH
- Child and Adolescent OPMH
- ATLAS Adolescent Day Hospital Program
- Diagnostic Clarification
- Treatment Recommendations
- Medication Review

Hospital MRN #: _____
Patient Name : _____ Last First
Date of Birth: _____ Sex: F M DD/MM/YYYY
Health Card #: _____ Version Code: _____
Address: _____ Postal Code: _____
Daytime Tel #: _____
Alternate Tel #: _____
Email: _____

Date Referral: _____		Referred by: <input type="checkbox"/> Family Physician <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other		Billing #: _____	
Referring Physician Name: _____			Physician Tel. #: _____		Physician Fax #: _____
Ref. Physician Address _____					Postal Code: _____
Primary language of patient: _____			Is an interpreter required? _____		
Next of Kin Name: _____			Contact #: _____		Is patient aware of referral? <input type="checkbox"/> Yes <input type="checkbox"/> No
Next of Kin Name: _____			Contact #: _____		Is family aware of referral? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does this patient currently have a psychiatrist? <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, name: _____		Phone #: _____
Reason for Referral _____ _____					
Main Diagnosis/Presenting Problem(s) <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Bipolar <input type="checkbox"/> Suicidal Ideation <input type="checkbox"/> Psychosis <input type="checkbox"/> OCD <input type="checkbox"/> School refusal <input type="checkbox"/> Complex Mental Health Issues <input type="checkbox"/> ADHD (child and adolescent only) <input type="checkbox"/> Other: _____					
Medication Please indicate all medication patient is currently taking					
Medication	Dose	Duration	Comments		
Please indicate all medication patient has taken in the past					
Medication	Dose	Duration	Comments		
Risks					
Threat to self	<input type="checkbox"/> Yes <input type="checkbox"/> No	When: _____			
Threat to others	<input type="checkbox"/> Yes <input type="checkbox"/> No	When: _____			
Suicidal Ideation	<input type="checkbox"/> Yes <input type="checkbox"/> No	When: _____			
Violent Behaviour	<input type="checkbox"/> Yes <input type="checkbox"/> No	When: _____			
*If there is imminent risk please refer to the emergency department for an assessment					
We do not offer forensic assessment or treatment, MVA assessment, or adult ADHD assessment or treatment.					
We are unable to provide assessments for legal, custody, disability, insurance or Workers Compensation issues, please confirm that this is not a referral for such a consultation. Confirmed <input type="checkbox"/>					
Physician Signature _____				Date _____	

