MARKHAM STOUFFVILLE HOSPITAL CORPORATION

Outpatient Mental Health
B.R.I.D.G.E. Day Treatment Program Referral Form

Fax: 905-472-7371
Telephone: 905-472-7373 ext. 6251

Client Information

Name:	**Date of Birth (MM/DD/YYYY):**	**Date of Referral:**
Address:		
Home telephone number:		
Cell phone number:		

Can a message be left at this number? ☐ **Yes** ☐ **No**

Referral Information

Referral Source:

☐ 1WF (In-patient Unit) Name: _____ Number: _____

☐ OPMH Name: _____ Number: _____

☐ Family Health Team Name: _____ Number: _____

☐ Nurse Practitioner Name: _____ Number: _____

Name of Attending Psychiatrist:_____

Reasons for Referral:

☐ Learn coping strategies ☐ Social Skills

☐ Stress Management ☐ Structure/Routine

☐ Symptom management ☐ Other (please specify): _____

Mental Health Diagnosis: ☐ Yes (please specify) ☐ No ☐ Unknown

Has this patient been referred to/or involved in any other OPMH programs? ☐ Yes ☐ No

☐ Art Therapy Group
☐ Cognitive Behavioural Therapy (CBT)
☐ Interpersonal Psychotherapy Group (IPT)
☐ Emotional Resilience Group (DBT)
☐ 1:1 Individual Counselling
☐ Concurrent Disorders Group
☐ Transitional Aged Youth CBT (TAY) *Ages 18 - 26
☐ Mindfulness Based Stress Reduction (MBSR)
☐ Women's Wellness Programs

Does this patient have any of the following: if yes, please provide additional information

☐ Suicidal ideations
☐ Homicidal ideations
☐ History of aggression/violent behaviours
☐ Substance use
☐ None
☐ Unknown

Additional Information: (i.e. Falls, seizures, epilepsy, etc.)

_____

_____

Are there currently any legal issues? If yes, please provide additional information. ☐ Yes ☐ No ☐ Unknown

Additional Information:

_____

_____