MARKHAM STOUFFVILLE HOSPITAL CORPORATION

381 Church St.
P.O. Box 1800
Markham, ON 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 ☐ Familly

☐ Ontario Dissability Support Program ☐ Employed - Occupation: _____

☐ Other: _____

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: _____