

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.*

- | | |
|--|--|
| <input type="checkbox"/> Adult OPMH | <input type="checkbox"/> Diagnostic Clarification |
| <input type="checkbox"/> Child and Adolescent OPMH | <input type="checkbox"/> Treatment Recommendations |
| <input type="checkbox"/> ATLAS Adolescent Day Hospital Program | <input type="checkbox"/> 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. #:
Ref. Physician Address		Physician Fax #:
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"/> Addictions (Adult) <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
Please indicate all medication patient has taken in the past		
Medication	Dose	Duration
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 _____

