William Osler Health System

Outpatient Mental Health (Centralized Intake and Triage)
REFERRAL FORM

Brampton Civic Hospital
Etobicoke General Hospital
Peel Memorial Centre
Community Mental Health Team
Phone: 905-494-6709
Fax: 905-494-6757

Patient Identification

Service Information

Referral Source ☐ ER/ UCC ☐ Acute Care ☐ Primary Health Care ☐ Other__________

William Osler Outpatient Mental Health offers short term psychiatric consultation, group psychotherapy, and limited short term individual psychotherapy for patients with mental health concerns. Services may be offered at the Brampton Civic Hospital, Etobicoke General Hospital, Peel Memorial Centre, or Queen Square Family Health Team's Community Mental Health Team.

INCLUSION CRITERIA
- Resides in Central West LHIN
- Provisional diagnosis of mental illness

EXCLUSION CRITERIA
- Actively suicidal or homicidal
- Requiring crisis assessment or hospital admission
- Assessments for court purposes or forensic psychiatry
- Completion of forms for insurance or medical purposes

Patient Information

Patient's Last Name: __________ **Patient's First Name:** __________

Date of Birth: (DD/MM/YY) __________ **Gender:** ☐ **Male** ☐ **Female** ☐ **Other**

Health Card Number: __________ **Version:** __________ **No OHIP:** ☐

Address: __________ **City:** __________ **Province:** __________ **Postal Code:** __________

Phone # (primary): __________ **Phone # (alternate):** __________ **Cell #:** __________

Patient's E-mail: __________ ☐ **Interpretation Services Required; Language:** __________

Person to contact for booking appointment *(If different than patient):* __________

Relationship to patient: __________

Can a message be left on the phone number provided? ☐ **Yes** ☐ **No**

If the patient is a child, who has parental custody/guardianship?__________

Reason for Referral & Relevant Patient History

URGENCY
☐ Urgent
☐ Routine (within 6 weeks)

AGE RANGE
☐ Child (<18) ☐ Adult

Reason for referral:
☐ Psychiatry Consult
☐ Mood & Anxiety Psychotherapy Program (Stepped Care Program)
☐ Psychosis Program (inc. Depot/Clozapine)
☐ Eating Disorders Clinic

Presenting Problem/Provisional Diagnosis:
____
____
____

Current Medications:
____
____

Referring Physician/Nurse Practitioner (NP) Information

Referring Physician/NP Name: __________ **OHIP Billing Number:** __________

Phone #: __________ **Fax #:** __________ **E-mail:** __________

Family Physician/NP *(If different from above)*: __________

Signature of Referring Physician/NP: __________ **Referral Date:** __________

Clinic Use Only
Date Referral Screened: __________
Date Appt. Booked: __________
Date of Appt.: __________

Referral Received Actions:
☐ Approved
☐ Patient Refused
☐ Redirected to __________
☐ Other __________