Phone: (905) 734-1141 x 2222 **Fax: (905) 734-1017**

IPC Mental Health & Addictions Team REFERRAL FORM

REFERRAL DATE:

____ ____ ____
dd mm yy

Surname:	**First name:**	**Gender:**
Address:	**City:**	**Postal code:**
Telephone #:	**Date of Birth** dd | mm | YY	**OHIP #:**

REFERRING PHYSICIAN / NP	**Name:**	**Tel #:**
		Fax#:

REASON(S) FOR REFERRAL

CURRENT CHALLENGES/CONCERNS

Describe current symptoms/clinical picture precipitating this referral & list any other mental health referrals made with date(s) of referral(s):

PSYCHOSOCIAL NEEDS (if applicable)

- ○ **Housing resources**
- ○ **Financial support applications**
- ○ **Client advocacy**
- ○ **Overcome barriers to service**
- ○ **Food security resources**
- ○ **Community connections/referrals**
- ○ **Employment and education**
- ○ **Other: _____**

PHQ-9 score: **GAD-7 score:**

FAX COMPLETED FORM (2 pages) TO 905-734-1017

Please note that our program is not an urgent support service and there is currently a wait list. We provide up to 8 sessions of psychotherapy in addition to psychosocial support. While we are partners in care of your patient, as their primary care provider you retain primary responsibility over their care.

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HAS THE PATIENT EVER EXPERIENCED ANY OF THE FOLLOWING?	YES	NEVER PROMINENT	IF YES, DESCRIBE (Date(s), severity/prevalence, any formal diagnoses)
Depressive Symptoms			
Anxiety Symptoms			
Self-Harm			
Suicide ideation/ Attempt(s)			
Acute Trauma – adult onset			
Complex Trauma			
OCD			
Manic/Hypomanic Symptoms			
Psychotic Symptoms			
Disordered Eating			
Borderline Personality Trait/Disorder			
Other Personality Trait/Disorders			
Harm to Others			
Psychiatric Hospitalisations			
Abuse/neglect			
Substance use/misuse			
Other Addictions (please specify)			

PSYCHIATRIC/PAIN MEDICATION(S)	DATE STARTED	COMMENTS: (reason for use, response, compliance)

ELIGIBILITY CHECK-LIST	
Please check box to confirm that the patient is willing and ready to engage in psychotherapy/counselling.	
Please check box to confirm that the patient has the cognitive capacity to engage with our services.	
Please check box to confirm that the patient is aware of any formal diagnoses listed above	
Please check box to confirm that patient has not had any episodes of mania or psychosis in the last 12 months.	
If the patient has been seen by a psychiatrist, please send consult notes with referral.	

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