IPC Mental Health and Addictions Team – Referral Form

For Referring Providers:

- A family physician or nurse practitioner referral is required if the patient is rostered
  - Patients of physicians and nurse practitioners working within a CHC or FHT are not eligible
- Patients may self-refer if they do not have a family physician or nurse practitioner
- The IPC Mental Health and Addictions Team does not offer:
  - Diagnostic assessment
  - Medication assessment/management
  - Assessment for legal purposes or insurance companies
  - Long-term psychotherapy

For Your Patient:

- Please ensure your patient is aware that the referral is being made
- Patients will be contacted to complete an intake assessment prior to seeing a therapist and/or caseworker
- Two attempts will be made to contact the patient. A letter will be sent to the referring provider if no contact is made.
- Some services may have a wait list
- Service locations throughout the Niagara Region:
  - St. Catharines
  - Niagara Falls
  - Welland
  - Fort Erie
  - Port Colborne

How to Refer to the IPC Mental Health and Addictions Team:

- Fax the completed referral form to **905-734-1017**
- Pages 1 and 2 must be completed in full for all referrals
- AVOID DELAYS – Incomplete referrals delay care for your patient. Ensure that all sections of the referral form are complete and all necessary information is included. Incomplete referrals will not be processed until all information has been received.
- For further inquiries, please call 905-734-1141 ext. 2222

Service Descriptions:

Individual Therapy

- Based on recognized therapeutic approaches
- Assessment of strengths and needs
- Short-term counselling and psychotherapy (maximum 12 sessions), education and support services
- Therapeutic group facilitation

Case Management

- Support individual's personal development (e.g., goal setting, daily coping skills, creating routines)
- Liaise and/or refer to community agencies (e.g., finding a family doctor, volunteer opportunities, accompaniments, employment)
- Assistance completing applications (e.g., government financial programs, geared-to-income housing)

Inclusion Criteria:

- Ages 12 and older *(Please consider referring youth ages 12-17 to Pathstone Mental Health or the Youth Wellness Hub Niagara – Francophone youth will be referred internally)*
- Be a resident of a town/city in the Niagara Region
- Be a patient of a family physician/nurse practitioner who works in private practice (CHC's and FHT's are excluded)

Exclusion Criteria:

- Patient presents with symptoms of a severe, complex mental illness (e.g., psychotic disorders, delusional disorders, bipolar disorders, cognitive impairment) with or without diagnostic clarification from a psychiatrist (determined on a case-by-case basis)
- Patient does not reside within the Niagara Region
- Patient is mandated by a court of law to participate in mental health services
- Patient is unable to consent and/or engage in therapy with or without a third-party representative present

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Date of Referral (DD/MM/YYYY): _____

Fax Referral Form to 905-734-1017

Patient Information

Name:
First Name: Last Name:

Preferred Name (if applicable):

Date of Birth (DD/MM/YYYY):

Gender: ☐ Male ☐ Female ☐ Intersex ☐ Trans-male ☐ Trans-female ☐ Two-spirited ☐ Other: _____ ☐ Do not know ☐ Prefer not to answer

Preferred Pronouns:
☐ He/him ☐ She/her ☐ They/them ☐ Other: _____

Health Card Information:
Health Card #: _____ Version Code: _____

Patient Address:
Address: _____ Unit #: _____
City: _____ Province: _____ Postal Code: _____

Patient Contact Information:
Primary Phone #: _____ Voicemail: ☐ Yes ☐ No
Alternate Phone #: _____ Voicemail: ☐ Yes ☐ No
E-mail Address: _____

Language of Preference: ☐ English ☐ French *Please note that we do not provide interpreter services.
Are there any accessibility concerns? ☐ Yes ☐ No If yes, please specify: _____

Referring Provider Information

Name:
First Name: Last Name:

☐ Family Physician
☐ Nurse Practitioner

Referring Provider Address:
Address: _____ Unit #: _____
City: _____ Province: _____ Postal Code: _____

Phone #:

Fax #:

Does your patient currently have a psychiatrist? ☐ Yes ☐ No ☐ Unknown
Has your patient been seen by a psychiatrist in the past? ☐ Yes ☐ No ☐ Unknown

*If yes, please attach relevant consultation notes with the referral.

Reason for Referral

Please indicate the primary reason for referral (specify diagnosis, current symptoms, presenting problems, psychosocial needs, and history):

Please select the service(s) you are seeking for your patient:
☐ Individual Therapy
☐ Case Management

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Substance Use
If applicable, please indicate current substances, amount, frequency of use, etc.:

Risks and Safety Concerns					
Risk Issue	Present (within past 3 months)		Past (3 months or more)		Details
	Yes	No	Yes	No	
Suicidal Ideation	☐	☐	☐	☐	
Suicide Attempt(s)	☐	☐	☐	☐	
Self-Harming Behaviour	☐	☐	☐	☐	
Homicidal Ideation	☐	☐	☐	☐	
Violent Behaviour/Safety Concerns	☐	☐	☐	☐	

Medication		
Medication	Current	Response & Adverse Effects
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	

History of Mental Health Care	
Organizations, hospitals or therapies involved within the past two years	Describe Involvement

Relevant Medical/Developmental History
Please indicate any disabilities (physical, cognitive or intellectual), neurodiversity and/or other issues if relevant.

*I confirm my patient is aware of this referral and has consented to collect, use or disclose a client's personal health information for the purpose of providing or assisting in providing health care. ☐ Yes ☐ No

Physician/NP Signature: _____

FAX COMPLETED REFERRAL (2 PAGES) TO 905-734-1017

Please note that our program is not an urgent support service and there is currently a waitlist. We provide up to 12 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.