The | Le Royal
Mental Health - Care & Research
Santé mentale - Soins et recherche

Central Intake Referral Form

Date of referral: __DD__ / __MM__ / __YYYY__

PATIENT INFORMATION

Patient Name: __________ Patient OHIP #: __________

DOB: __DD__ / __MM__ / __YYYY__ Gender: __________ Occupation: __________

Patient Address: __________ Patient phone #: __________

Language of service: ❑ English ❑ French ❑ Other: __________ Interpreter required? ❑ Yes ❑ No

Does your patient have any accessibility needs? __________

Alternate contact name: __________ Alternate contact phone #: __________

REFERRAL INFORMATION *– Please indicate the requested service and setting of care – select one.*

OUTPATIENT

❑ Mood/Anxiety ❑ Schizophrenia ❑ Forensics – *General* ❑ Forensics – *Sexual Behaviours Clinic*

❑ Dual Diagnosis* ❑ Substance Use & Concurrent Disorders

****Note:** If you are referring your patient to the **Dual Diagnosis program**, program, please provide all psychological assessment records if available.*

INPATIENT *(Referrals to the Mood/Anxiety or Schizophrenia programs will only be considered from other hospitals)*

❑ Mood/Anxiety ❑ Schizophrenia ❑ Youth ❑ Substance Use/Concurrent Disorders ❑ Recovery* – Integrated Schizophrenia Program

If **Recovery program is requested, the **patient's** goals for admission **must** be listed below*

1) __________

2) __________

3) __________

REASON FOR REFERRAL *(Mandatory field – please be specific)*

Why are you referring the patient now?

❑ Diagnostic clarification ❑ Medication recommendations ❑ Treatment recommendations

Why are you referring the patient now? *– Current symptoms, presenting problem, and/ or recent changes in mental status*

PSYCHIATRIC HISTORY *– Please attach any applicable consults or admission record*

Psychiatric Diagnosis (suspected or known): __________

Date of last psychiatric assessment, if applicable: __DD__ / __MM__ / __YYYY__

Date of last psychiatric hospitalization, if applicable: __DD__ / __MM__ / __YYYY__

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Patient Name: ______________________ DOB: DD / MM / YYYY

MEDICAL INFORMATION

MEDICAL HISTORY

MEDICATIONS – *Please clearly indicate all current and/or past medications; attach a separate sheet if more space is required. If your patient has no current or past medications, please indicate this below.* ***(Mandatory Field – referrals will not be processed without this information)***

Current Medications	Dose	Frequency	Date Started

Past Psychiatric Medications	Dose	Frequency	Date Started and Discontinued

Allergies: ❑ No ❑ Yes If yes, please list: ______________________

Pharmacy: ______________________ **Pharmacy Phone and/or Fax #:** ______________________

RISK – *Please indicate any applicable safety risks and elaborate below*

❑ Suicidal ideation ❑ Homicidal Ideation ❑ History of verbal/physical aggression ❑ Falls ❑ Self-neglect ❑ Self-harm

SUSBTANCE USE ❑ None

SUBSTANCE	AMOUNT	FREQUENCY	LENGTH OF USE (days, months, years)	CURRENT USE? Y/N (If not current, please indicate date of last known usage)
Alcohol				
Cannabis				
Opioids:				
Stimulants:				
Other (specify):				

LEGAL INFORMATION

Does the patient have any outstanding charges? ❑ Yes ❑ No ❑ Unknown

If yes, please state charges and indicate any upcoming court dates: ______________________

Is the patient currently on probation? ❑ Yes ❑ No ❑ Unknown

If yes, please indicate duration and any upcoming court dates: ______________________

Is the patient currently under the Ontario Review Board? ❑ Yes ❑ No ❑ Unknown

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CONSENT & CAPACITY

Current MHA legal status: ❑ Not Applicable ❑ Voluntary ❑ Involuntary ❑ Informal

If involuntary, please indicate current MHA form: ❑ Form 1 ❑ Form 3 ❑ Form 4 ❑ other: ______________

Is the patient aware and in agreement with this referral? ❑ Yes ❑ No

Is the patient aware that we will obtain past reports from hospitals/mental health agencies? ❑ Yes ❑ No (*complete attached Schedule A*)

Does patient consent to the disclosure of these past records to The Royal? ❑ Yes ❑ No

Is the patient capable to consent to treatment? ❑ Yes ❑ No ❑ Unknown

If no, please identify their Substitute Decision Maker/ Power of Attorney/ Public Guardian & Trustee

Name: ______________________ Phone #(s): ______________

Is the patient aware that The Royal is a research hospital and as such, they may be contacted to discuss participation in research studies? ❑ Yes ❑ No

COMMUNITY SUPPORTS – *Please indicate full name and contact information*

General practitioner / Nurse practitioner *(if different from referring source)*	
Community Agency	
Probation Officer	
Other Mental Health Supports *Psychiatrist, Psychologist, Social Worker, etc.*	

REFERRAL SOURCE INFORMATION – *Mandatory field*

Will you continue to provide care for this patient once discharged from our program? ❑ Yes ❑ No

If no, please indicate who will resume care or follow up ❑ GP ❑ NP ❑ Psychiatrist

Provider name: ______________________ Phone #: ______________ Fax #: ______________

Referral Source Name: ______________________ ❑ GP ❑ NP ❑ Psychiatrist

Referral Source CPSO # ______________________ Referral Source OHIP Billing # ______________________

Referral Source Phone #: ______________________ Referral Source Fax #: ______________________

Referrer Signature: ____

Please fax your completed referral to
Central Intake: (613) 798-2976

Questions?
Please feel free to contact us at (613) 722-6521 ext. 6211 for support

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SCHEDULE A

The Royal respects the privacy laws in Ontario which require us to protect your privacy by protecting your personal information. We will ensure the confidentiality of any information you give or that is gathered about you during the course of your stay at The Royal. The Royal requires your consent to obtain past records from hospitals and/or mental health agencies in order to provide you with the highest quality of care.

I, ______________________________, confirm that I understand my rights pertaining to the above. Consequently, I understand that I have the right to either accept or decline the disclosure listed below.

PLEASE CHECK ONE BOX

Disclosure of past reports from hospitals and/or mental health agencies: ❑ Yes ❑ No

I agree to the referral to The Royal for services ❑ Yes ❑ No

I am signing my name below to confirm that I have read the above or it has been read to me, and I have had a chance to discuss it with a staff member.

Name: ______________________________

Signature: ______________________________ Date: DD / MM / YYYY

Staff Witness:

Name: ______________________________

Signature: ______________________________ Date: DD / MM / YYYY