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

Referral Form

Please return the completed referral form by:

Fax: 613.798.2976 *(preferred)* or

Mail to: The Royal
Central Intake Office,
1145 Carling Ave. Ottawa, Ontario K1Z 7K4

Please contact The Royal at:
613.722.6521 ext. 6211 or by
email at Central.Intake@theroyal.ca
if you have any questions.

Patient Demographics (Addressograph or Patient Label)

We will review all referrals for potential consultations, assessment or treatment at The Royal. The referring physician will be advised about the outcome of the referral and treatment recommendations.

PATIENT INFORMATION

Date of referral: DD / MM / YY

Type of service requested: ❑ Inpatient ❑ Outpatient

If service is INPATIENT, which program would you like the patient to be referred to? Please select one.

❑ Recovery ❑ Substance Use & Concurrent Disorders
❑ Schizophrenia ❑ Mood/Anxiety

If service is OUTPATIENT, which program would you like the patient to be referred to? Please select one.

❑ Dual Diagnosis ❑ Substance Use & Concurrent Disorders
❑ Schizophrenia ❑ Mood/Anxiety
❑ Forensic ❑ Recovery

Name of Family Physician/General Practitioner:_____ Telephone:___ /___ /___

Address: _____

Language of service: ❑ English ❑ French ❑ Interpreter required - *Interpreter language:*_____

Permission to leave voicemail: ❑ No ❑ Yes

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Patient Name: _____ Date of Birth: _____

REASON FOR REFERRAL

Role of referrer: ❑ Psychiatrist ❑ Nurse practitioner ❑ General practitioner Other: _____

Referrer Last Name: _____ Referrer First Name: _____

Telephone No.: ___/___/___ x _____ Fax: ___/___/___

❑ Diagnostic clarification ❑ Medication recommendations ❑ Community resources

❑ Treatment ❑ CBT for mood/anxiety disorders ❑ Other, please specify: _____

Why are you referring the patient now? *(e.g. current symptoms, presenting problems, history of frequent ER visits/police contact, imminent risk to self/others, recent changes mental status, goals for assessment)*

_____

Psychiatric Diagnosis *(suspected or known)*

MEDICAL INFORMATION

Please list all current medications and previously trialled psychiatric medications. Enter the list below separated by commas. Note that no referral can proceed until a medication list has been provided.

Medications

Current Medication(s)	Dose	Frequency	Date Started
Past Psychiatric Medication(s)	**Dose**	**Frequency**	**Date Started**

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

Please attach pre-sentence report, account of offence, previous psych reports, any corresponding documents.

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Patient Name: _____ Date of Birth: _____

Substance Use *(suspected or known)* *Please describe in detail if patient has current or a history of substance use. Indicate when, how long, quantity, frequency and drug used. Please repeat for each occurrence of drug used and/or major changes to usage (e.g. withdraw, relapse). Attach sheet if necessary.*

LEGAL INFORMATION

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

If yes, please describe:

CONSENT

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

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

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

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

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

Name: _____ Telephone: ___/___/___ x _____

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

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Patient Name: _____ Date of Birth: _____

TO BE COMPLETED BY THE REFERRING SOURCE *(mandatory)*

Is the patient currently enrolled with Health Links Ontario? ❑ No ❑ Yes

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

If no, please identify who will resume care or follow-up? ❑ GP ❑ Psychiatrist

Physician Name: _____ Telephone:___/___ /___ Fax:___ /___/___

If referring a patient to the Regional Dual Diagnosis Consultation Team (RDDCT)
please provide the following documentation: Psychological Assessment and Relevant developmental history
(e.g. Disabilities, intellectual delay, autism or other issues). ❑ No ❑ Yes

REFERRING INSTITUTION

Name: _____

Service *(please include one abbreviation code only):*_____ (ie. AM - Ambulatory Care)

RECOVERY PROGRAM REFERRALS ONLY

Patient goals of admission: A) _____

B) _____

C) _____

REFERRAL FORM MUST HAVE APPROPRIATE SIGNATURE FOR COMPLETION

Date: _____ Completed by *(Print name):* _____

Signature and Designation: _____

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Central Intake Referral Form

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: ❑ No ❑ Yes

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

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 / YY

Staff Witness:

Name: _____

Signature: _____ Date: DD / MM / YY