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

Central Intake Referral Form

Date of referral: _____ / _____ / _____

PATIENT INFORMATION

Client Name: _____ Client OHIP #: _____

DOB: DD / MM / YYYY Gender: _____ Occupation: _____

Patient Address: _____ Patient phone #: _____

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

Does your client have any accessibility needs? _____

Alternate contact name: _____ Alternate contact phone #: _____

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

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

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

*If **Recovery** program requested, please indicate the patient's goals for admission **(Mandatory field):***

1) _____

2) _____

3) _____

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**, please provide all psychological assessment records.*

Psychiatric Diagnosis (suspected or known): _____

Why are you referring the patient now? *- Please indicate your clinical perspective with respect to your client's current symptoms, presenting problem, and/ or recent changes in mental status. **(Mandatory field – please be specific)***

❑ Diagnostic clarification ❑ Medication recommendations ❑ Treatment recommendations

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

Date of last psychiatric assessment, if applicable: DD / MM / YYYY

Date of last psychiatric hospitalization, if applicable: DD / MM / YYYY

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

Case Manager	
Community Agency	
Probation Officer	
Other Mental Health Supports *Psychiatrist, Psychologist, Social Worker, etc.*	

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Patient Name: _____ DOB: DD / MM / YYYY

MEDICAL INFORMATION

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

MEDICATIONS – *Please clearly indicate all current and/or past medications; attach a separate sheet if more space is required. If your client 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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Patient Name: _____ DOB: DD / MM / YYYY

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): _____

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