

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

- Adult General Psychiatry 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)

- Adult General Psychiatry 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

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): _____

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 <i>(if different from referring source)</i>	_____
Community Agency	_____
Probation Officer	_____
Other Mental Health Supports <i>Psychiatrist, Psychologist, Social Worker, etc.</i>	_____

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

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:

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