St. Joseph's Healthcare Hamilton | Connect Mental Health and Addiction Outpatient Programs

Provider Referral Form
Instructions and Information

Phone: (905) 522-1155, Ext.36499
Fax: (905) 389-3815
Email: connectmhap@stjoes.ca
www.stjoes.ca/connectmhap

PLEASE DO NOT FAX COVER PAGE

The Mental Health and Addiction Program at St. Joseph's Healthcare Hamilton specializes in the assessment and treatment of mental illness and addiction. We offer evidence-based services in anxiety disorders, mood disorders, schizophrenia and psychotic disorders, neurocognitive disorders, eating disorders, borderline personality disorder and emotion regulation difficulties, substance use disorders, mood difficulties related to the reproductive cycle, and dual diagnosis (combined mental health concerns and intellectual disabilities). The services are primarily offered for transition aged youth (17-25), adults and seniors.

Questions about the referral process? Please call: 905-522-1155, x. 36499, or Email: connectmhap@stjoes.ca

In order to help us provide the best care, please include the following (if possible):

- Relevant lab and test results
- Previous psychiatric consultations or discharge summaries
- List of medications (past and present medications, please attach pharmacy medication list)
- Physical findings
- Psychological/psychiatric reports

Please note for the following services:

- For the **Assertive Community Treatment Team (ACTT)**, please **fax** completed form to
    - Hamilton ACTT (ACTT1 and ACTT2) - Fax 905-528-8442
    - Brant ACTT - Fax 519-758-1971
    - Haldimand Norfolk ACTT - Fax 519-426-0971

- For **Centralized Rehabilitation Resource Clinic (CRRC)** please **also** complete and submit the supplemental form found on www.stjoes.ca/crrc and **fax** to 905-381-5612.
- For **Dual Diagnosis** referrals, patient must have a Global IQ of 70 or less prior to their 18th birthday. (Please **also** attach the neuropsychological testing report if available).
- For **Eating Disorder** referrals, please **also** complete the Eating Disorders Referrals Section of this form.

Other Information:

Patient and Family Collaborative Support Services: Offers peer support for individuals and family members of individuals with lived experience of a mental health or addiction issue. Please contact 905-522-1155 ext. 39559. Self-referrals are welcome.

Research Participation: Eligible patients may be contacted by St. Joe's researchers to gauge their interest in research participation. The choice to participate in research or not will have no effect on patient care. Patients may withdraw from research contact at any time by informing their care team at St. Joe's.

There may be a wait for service.

If your patient is in crisis and is requiring immediate help, please contact your local crisis service or direct them to your nearest emergency department.

Hamilton COAST	Haldimand Norfolk CAST	Niagara COAST	Brant St. Leonard's	Halton COAST
(905-972-8338) Barrett Centre (1-844-777-3571)	1-866-487-2278	1-866-550-5205, x. 1	519-759-7188 or 1-866-811-7188	1-877-825-9011

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Client/Patient Information

* Last Name:
* Legal Name:
Preferred Name:
Date of Birth: (yyyy/mm/dd)
Health Card Number:
VC:
Address:
Unit:
City:
Postal Code:
Gender: ☐ Male ☐ Female ☐ Transgender ☐ Prefer not to answer
☐ Prefer to self-identify:
*Primary Contact Phone: ☐ Mobile ☐ Landline
Can a message be left at this number? ☐ No ☐ Yes
Can we use text for communication? ☐ No ☐ Yes
If yes, number to text:
Can we use email for communication? ☐ No ☐ Yes
If yes, email address:
Alternate Contact Information:
Consent to contact? ☐ No ☐ Yes
Community Treatment Order? ☐ No ☐ Yes (If **Yes**, include CPT & CTO)
Capable to make treatment decisions? ☐ No ☐ Yes (If **No**, include Form 33)
Substitute Decision Maker (SDM): ☐ No ☐ Yes (If **Yes**, include Form 33)
SDM Name:
Relationship:
Phone:
Emergency Contact Name:
Relationship:
Phone:

Referral Source Information

* Provider Referring:
Facility:
Specialty:
Billing #:
Contact Person:
* Phone:
Backline:
Fax:
Does client have a family physician? ☐ No ☐ Yes
Name of family physician:
Is family physician part of FHT? ☐ No ☐ Yes
If yes, have internal services been accessed?
☐ No ☐ Yes (Please attach records)

Consent

* Patient is aware of this referral and has consented to their health information being collected from various sources to make decisions regarding care. ☐ No ☐ Yes

Special Needs

Preferred Language: ☐ English
☐ Other
Is an interpreter required? ☐ No ☐ Yes
☐ Cognitive Impairment ☐ Hearing Impairment
☐ Sight Impairment ☐ Mobility/Fall Risk
☐ Sensory (smell/light) ☐ Unable to attend clinic
☐ Other:

Presenting Concerns/Referral Goal (i.e. diagnostic clarification, medication review, 2nd opinion, treatment)

* Reason for Referral: ☐ New Request ☐ Re-referral
* Indicate Urgency: ☐ Urgent (< 2 weeks) ☐ Non-urgent
* **Please describe presenting problems, current symptoms, and reason for urgency:**

How long has this been a concern? ☐ Less than one month ☐ 1-6 months ☐ More than 6 months
Currently receiving treatment for this concern? ☐ No ☐ Yes
If yes, Provider name, discipline and type of treatment:

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Client/Patient Name: _____

Past/Present Psychiatric Diagnoses

	Past	Present		Past	Present
Bipolar Disorder	☐	☐	Anxiety Disorder	☐	☐
Schizophrenia/Schizoaffective	☐	☐	Depression	☐	☐
Eating Disorder	☐	☐	Psychosis (Hallucinations/Delusions)	☐	☐
Personality Disorder _____	☐	☐	Neurocognitive Disorder	☐	☐
Post Traumatic Disorder	☐	☐	Other: _____	☐	☐

Treatment History - (Please attach assessments, discharge summaries, progress notes from other agencies, hospitals or therapies)

Hospital admission(s) for: mental health concerns: ☐ No ☐ Yes addiction concerns: ☐ No ☐ Yes

ER visit(s) for: mental health concerns: ☐ No ☐ Yes addiction concerns: ☐ No ☐ Yes

Involvement with other agencies and/or therapy? ☐ No ☐ Yes

Please provide details of when, where and outcome of treatment history. Information is necessary to complete intake process.

Medical History (Please attach relevant CURRENT and PAST medical information, i.e. respiratory, cardiac, metabolic)

Please Describe:

Indicate all that apply:

☐ Acquired Brain Injury ☐ Developmental Disability ☐ Neurological Disorder ☐ Pregnant/Post-partum Due Date: _____

Substance Use

Use alcohol or drugs weekly or more often? ☐ No ☐ Yes

Spend a lot of time either getting, using or recovering from the effects of alcohol/drugs? ☐ No ☐ Yes

Continue to use alcohol or drugs even though it's causing problems? ☐ No ☐ Yes

Experience withdrawal problems or use substances to stop being sick? ☐ No ☐ Yes

Substance: _____ Amount Used: _____ Frequency: _____

Substance: _____ Amount Used: _____ Frequency: _____

Substance: _____ Amount Used: _____ Frequency: _____

Risk Issues (Please check all that apply)

Risk Issue	Yes	No	If Yes, when?	Details
Suicide Attempt	☐	☐		
Suicide Ideation	☐	☐		
Deliberate Self-harm	☐	☐		
Homicidal Threats/Ideation	☐	☐		
Violent/Aggressive Behaviour	☐	☐		
Legal Involvement	☐	☐		
Homelessness/Risk of	☐	☐		
Lives Alone	☐	☐		
Other:				

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Medication/Supplements: (PSYCHIATRIC and NON-PSYCHIATRIC medications including opiate replacement therapies. Please attach additional information if required.)

Medication	Dose/Frequency	Current	Past	Start Date	Response/Adverse Effects
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		

Eating Disorders Clinic Referrals: Please complete the following sections and submit with the required investigations

Please note the SJHH Eating Disorders Clinic is an outpatient clinic and does not have day hospital or inpatient treatment and does not offer meal supervision. Referral is for consultation/recommendations. Treatment will be offered if appropriate. Considerations include medical stability, symptom severity, psychiatric comorbidity. Clients must have a BMI over 16.

Current Physical Status: Please complete in full as this information is necessary to determine appropriate treatment

Height (cm): _____ Weight (kg): _____ BMI: _____

Weight Loss: ☐ No ☐ Yes Weight Gain: ☐ No ☐ Yes Please indicate change: _____ kg over _____ (time period)

Has this patient ever received treatment for his/her eating disorder? ☐ No ☐ Yes

If yes, where and when: _____

Current Symptoms: Please check all that apply and include frequency. Information is necessary to determine appropriate treatment.

Symptom	Yes	No	Details/Frequency	Symptom	Yes	No	Details/Frequency
Restriction and/or Fasting	☐	☐		Diet Pills	☐	☐	
Binge Eating	☐	☐		Insulin Restriction	☐	☐	
Vomiting	☐	☐		Diuretics	☐	☐	
Laxatives	☐	☐		Extreme distress with weight and shape	☐	☐	
Extreme Exercise	☐	☐		Other: _____	☐	☐	

Current Investigations: Mandatory - Please attach results from within the last three months.

☐ ECG	☐ Calcium	☐ Glucose	☐ TSH	☐ Alkaline Phosphatase
☐ CBC & Diff	☐ Magnesium	☐ Urea	☐ ALT	☐ Vitamin B12
☐ Electrolytes	☐ Phosphate	☐ Creatinine	☐ GGT	☐ Ferritin

☐ If Binge Eating is the **only** reported symptom, please **also** complete Fasting Lipids

If your patient is in crisis and requiring immediate help, please contact your local crisis service or direct them to your nearest emergency department. In Hamilton, contact COAST (905-972-8338) or Barrett Centre (Toll Free 1-844-777-3571), in Haldimand Norfolk contact CAST (1-866-487-2278), in Niagara contact COAST Niagara (1-866-550-5205, ext. 1), in Brant contact Integrated Crisis Services; St. Leonard's (519-759-7188 or 1-866-811-7188), and in Halton contact COAST Halton (1-877-825-9011).

_____ Referral Source Signature

_____ Date Signed (yyyy/mm/dd)