| Date: (yy/mm/dd) | Name of Individual: Last, First | | | DOB: (yy/mm/dd) | | | | | | | | CID: | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | | | | | | | | | | | | |
| Request for (18 years of age and older) Adult Outpatient Mental Health Service: FAX FORM TO HERE 24/7  @ FAX: 1-844-437-3329 | | | | | | | | | | | | | | | | | |
| Please Choose One | | | | | | | | | | | | | | | | | |
| Urgent Response - For Mental Health Services (counselling) | | | | | | | | | | | | | | | | |  |
| Urgent Response - For Psychiatry Consultation | | | | | | | | | | | | | | | | |  |
| Non-Urgent Responses - For Mental Health Services/Groups (anxiety, mindfulness, DBT skills, CBT, counselling, symptom management, concurrent disorders | | | | | | | | | | | | | | | | |  |
| Non-Urgent Responses - For Psychiatry Consultation | | | | | | | | | | | | | | | | |  |
| \*\*\*Please ensure this form is fully completed to avoid delay in processing\*\*\* FAX FORM TO HERE 24/7 @FAX: 1-844-437-3329 | | | | | | | | | | | | | | | | | |
| Patient Information – Affix label | | | | | | | | | | | | | | | | | |
| Address: | |  | | | | | | | | | | | | | | | |
| Health card #: | |  | Version code: | | | | | |  | | | | | | | | |
| Home phone: | |  | Cell: | | | | | |  | | | | | | | | |
| Confirm phone numbers | | | | | | | | | | | | | | | | | |
| Home phone: | |  | | | Cell: | | | |  | | | | | | | | |
| Healthcare Practitioner Information | | | | | | | | | | | | | | | | | |
| Referring practitioner: | |  | | | | | | | | | | | | | | | |
| Direct phone (back line): | |  | | | | Fax: | | |  | | | | | | | | |
| Physician billing #: | |  | | | | | | | | | | | | | | | |
| Has the patient been involved with Mental Health Services or Psychiatry in the past? | | | | | | | |  | | | Inpatient | | |  | | Outpatient | |
| What is the clinical history and clinical question you would like answered? What have you already tried? (please be detailed and specific regarding signs, symptoms, and diagnosis if available). | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| If yes, specify where and when service was provided. Include collateral documentation, SW and MH team notes. | | | | | | | | | | | | | | | | | |
| Is patient aware of and agreeable to referral | | | | | | |  | | | Yes | | |  | | No | | |
| Healthcare practitioner: | |  | | | Date: | | | |  | | | | | | | | |
| Please attach current and historical medication list and allergies  FAX FORM TO HERE 24/7 @ FAX: 1-844-437-3329 | | | | | | | | | | | | | | | | | |
| CC: Client Family:       Date:  Referral Source/GP:       Date:  Other:      Date: | | | | | | | | | | | | | | | | | |