| 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:        |