| Date: (yy/mm/dd) | | | | | | | | Name of Individual: Last, First | | | | | | | | | | | | | | | | | | | | | | DOB: (yy/mm/dd) | | | | CID: | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Required Eligibility Checklist | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | 18 years-of-age and older residing in Kitchener (or residing in an area without psychiatric resources) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Moderate to severe diagnosis and/or diagnosable disorder (bipolar, schizophrenia, psychosis, severe depression, anxiety, obsessive compulsive disorder, significant trauma) with complex needs arising from mental health conditions and/or concurrent disorders | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Primary Care Provider has tried previous interventions that have not been successful at stabilizing the person | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Those typically not eligible:   * People with mild to moderate symptoms who can be served within an EAP, family counselling or private therapist. * People who experience age related cognitive decline (e.g., dementia) are better served by senior services | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Consultation Requested | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Consultation type: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Assessment & diagnosis | | | | | | | | | | | | | | | | | | |  | | Medication | | | | | | | | |  | | Treatment planning | | | |
| Type of appointment: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | New patient | | | | | | | | | | | | | | | | | | |  | | Follow-up consultation | | | | | | | | | | | | | | |
| Priority - *Refer to priority queue*: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | A |  | B | |  | | C | | |  | | D | |  | | E | |  | | F | |  | G | | | | | | | | | | | | | | |
| Patient Demographics | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Age: | | | | | |  | | | | | | | | | Gender: | | | | | | | | |  | | | | | Ethnicity: | | | |  | | | |
| Address: | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Phone: | | | | | |  | | | | | | | | |  | | | | Message okay | | | | | | | | | | Alternate: | | | |  | |  | Message okay |
| Health card #: | | | | | |  | | | | | | | | | | | | | | | | | | | | | Version code: | | | | | |  | | | |
| Preferred language: | | | | | | | | |  | | EN | | | |  | | | | FR | |  | | | | | | | | | Other: | | |  | | | |
| Healthcare Providers: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Physician: | | | | | |  | | | | | | | | | | | | | | | | | | | | | Billing #: | | | | | |  | | | |
| Organization: | | | | | |  | | | | | | | | | | | | | | | | | | | | | Phone: | | | | | |  | | | |
| Address: | | | | | |  | | | | | | | | | | | | | | | | | | | | | Fax: | | | | | |  | | | |
| Name: | | | | | |  | | | | | | | | | | | | | | | | | | | | | Type: | | | | | |  | | | |
| Organization: | | | | | |  | | | | | | | | | | | | | | | | | | | | | Phone: | | | | | |  | | | |
| Address: | | | | | |  | | | | | | | | | | | | | | | | | | | | | Fax: | | | | | |  | | | |
| Psychiatric Symptoms - Duration of Symptoms *Please check any that apply:*: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Depressed mood | | | | | | | | | | | | | | | | | |  | | Other anxiety symptoms | | | | | | | | | |  | | Attention deficit/ hyperactivity | | | |
|  | Elevated mood | | | | | | | | | | | | | | | | | |  | | Excessive somatic symptoms | | | | | | | | | |  | | Personality problems | | | |
|  | Fluctuating mood (mood swings) | | | | | | | | | | | | | | | | | |  | | Sleep disturbance | | | | | | | | | |  | | Unusual behaviour | | | |
|  | Suicidal thoughts/ actions/ behaviours | | | | | | | | | | | | | | | | | |  | | Delusions | | | | | | | | | |  | | Alcohol abuse | | | |
|  | Obsessive thoughts | | | | | | | | | | | | | | | | | |  | | Hallucinations | | | | | | | | | |  | | Other substance abuse/ speciality drugs: | | | |
|  | Compulsive behaviours: | | | | | | | | | | | | | | | | | |  | | Disorganized thought processes: | | | | | | | | | |  | | Phobia(s): | | | |
|  | Confusion | | | | | | | | | | | | | | | | | |  | | Abnormal eating behaviours: | | | | | | | | | |  | | Panic symptoms or attacks | | | |
|  | Memory impairment | | | | | | | | | | | | | | | | | |  | | Intellectual disability | | | | | | | | | | | | | | | |
|  | Other current psychiatric symptoms: | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |
| Medical/Physical Issues - *Please check any that apply:* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Chronic pain: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Significant medical/physical illness: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Physical symptoms other than chronic pain: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Difficulty coping with physical illness: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Medication issues: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Other: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Living Arrangements | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please check the person’s living arrangements: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Self | | | | | | | | | | | | | |  | | | | Spouse/partner and others | | | | | | | |  | | Children | | | | |  | Parents | |
|  | Relatives | | | | | | | | | | | | | |  | | | | Non-relatives | | | | | | | |  | | Unknown/service recipient declined | | | | | | | |
| Employment | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please check the person’s employment status: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Independent/competitive (Self) | | | | | | | | | | | | | |  | | | | Independent/ competitive (FT) | | | | | | | |  | | Assisted/ supportive | | | | |  | Alternate business | |
|  | Sheltered workshop | | | | | | | | | | | | | |  | | | | Non-paid work experience | | | | | | | |  | | No employment | | | | |  | Casual /sporadic | |
|  | No employment of any kind | | | | | | | | | | | | | |  | | | | Independent/competitive (PT) | | | | | | | | | | | | | | | | | |
| Pharmacy - *if known* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Address: | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Phone: | | | |  | | | | | | | | | | | | | | | Fax: | | |  | | | | | | | | | | | | | | |
| Psychosocial Issues – Symptoms *Please check any that apply:*: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Marital/common-law/partner problem | | | | | | | | | | | | | | | | | |  | | Illness in family member | | | | | | | | | | |  | School problems | | | |
|  | Separation/divorce | | | | | | | | | | | | | | | | | |  | | Other family problems | | | | | | | | | | |  | Work problems | | | |
|  | Other relationship issues | | | | | | | | | | | | | | | | | |  | | Alcohol abuse in family member | | | | | | | | | | |  | Accommodation | | | |
|  | Sexual problem | | | | | | | | | | | | | | | | | |  | | Past alcohol abuse in self | | | | | | | | | | |  | Unemployment | | | |
|  | Self esteem | | | | | | | | | | | | | | | | | |  | | Lack of social support/social isolation | | | | | | | | | | |  | Financial issues | | | |
|  | Anger/temper control | | | | | | | | | | | | | | | | | |  | | Physical/sexual abuse during childhood | | | | | | | | | | |  | Legal issues | | | |
|  | Parent/child issues | | | | | | | | | | | | | | | | | |  | | Past physical/sexual abuse - victim | | | | | | | | | | |  | WSIB issue | | | |
|  | Bereavement | | | | | | | | | | | | | | | | | |  | | Current physical/sexual abuse (partner) | | | | | | | | | | |  | Insurance form/letter to be prepared | | | |
|  | Child behaviour problems | | | | | | | | | | | | | | | | | |  | | Other current abuse | | | | | | | | | | |  | Other stressful events | | | |
|  | Other (specify): | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Supplemental Information: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| To reduce duplication, information already available in the system is highly valued and should be attached to this referral: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medical/psychological/psychiatric history | | | | | | | | | | | | | | | | | | | |  | | Attached | | | | Other assessments | | | | | | | | |  | Attached |
| Hospital discharged summaries | | | | | | | | | | | | | | | | | | | |  | | Attached | | | | Previous investigation (e.g., ECG, CT/MRI, echo) | | | | | | | | |  | Attached |
| Psychiatric hospitalization(s) | | | | | | | | | | | | | | | | | | | |  | | Attached | | | | Medications list | | | | | | | | |  | Attached |
| Recent laboratory results | | | | | | | | | | | | | | | | | | | |  | | Attached | | | | | | | | | | | | | | |
| Current Medications List: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Attached | | | | | Specify: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| Reason For Referral: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Purpose for referral | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | One time consultation for diagnostic clarification and treatment recommendations | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | One-time consultations for diagnostic clarification only | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | One time consultation for treatment recommendations only | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Clinical question: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Brief description of presenting issues: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Relevant medical history: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Past psychiatric history - *Please enclose any previous psychiatric consultations*: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other relevant Information: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Allergies: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| History of drug interactions: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Has this patient been a psychiatric inpatient? | | | | | | | | | | | | | | | | | | | | | | | |  | Yes | |  | No | | If yes, where, and when *– answer below*: | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Completed by: | | | | | | | | | | | | | | | | |  | | | | | | | | | | Position: | | | |  | | | | | |
| Referring physician signature: | | | | | | | | | | | | | | | | |  | | | | | | | | | | Billing #: | | | |  | | | | | |
| CC: Client Family:       Date:  Referral Source/GP:       Date:  Other:      Date: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |