| 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:        |