| Date: (yy/mm/dd) |  Name of Individual: Last, First | CID:       |
| --- | --- | --- |
|  |
| Client/Patient Information |
| Address: |       |
| Date of Birth: |       |
| Health Card:  |       | Version Code: |       |
| Home Phone: |       | Cell Phone: |       | [ ]  | Ok to text |
| REQUIRED ELIGIBILITY CHECKLIST |
| [ ]  | 18 years-of-age and older residing in Guelph, Waterloo, or Wellington |
| [ ]  | 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 |
| [ ]  | Without psychiatric consultation and intervention, the person is likely to become unstable |
| 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: |
| [ ]  | Urgent | [ ]  | Elective |
| HEALTHCARE PROVIDERS |
| Name: |       | Type: |       |
| Organization: |       | Phone number: |       |
| Address: |       | Fax number: |       |
| Name: |       | Type: |       |
| Organization: |       | Phone number: |       |
| Address: |       | Fax number: |       |
| PSYCHIATRIC SYMPTOMS |
| Please check any that apply: |
| [ ]  | Depressed mood | [ ]  | Delusions | [ ]  | Elevated mood |
| [ ]  | Hallucinations | [ ]  | Confusion | [ ]  | Fluctuating Mood (Mood Swings) |
| [ ]  | Attention Deficit/Hyperactivity | [ ]  | Memory Impairment | [ ]  | Suicidal Thoughts/Actions/Behaviours |
| [ ]  | Personality Problems:       | [ ]  | Obsessive Thoughts:        | [ ]  | Other Substance Abuse in Self |
| [ ]  | Unusual Behaviour | [ ]  | Compulsive Behaviours:  | [ ]  | Abnormal Eating Behaviours:       |
| [ ]  | Alcohol Abuse In Self | [ ]  | Phobia(s):       | [ ]  | Intellectual Disability |
| [ ]  | Sleep Disturbance | [ ]  | Panic Symptoms or Attacks | [ ]  | Excessive Somatic Symptoms |
| [ ]  | Excessive Somatic Symptoms | [ ]  | Other Anxiety Symptoms       |
| MEDICAL/PHYSICAL ISSUES |
| Please check any that apply: |
| [ ]  | Chronic Pain:       | [ ]  | Difficulty coping with physical illness |
| [ ]  | Physical Symptoms Other Than Chronic Pain:       | [ ]  | Medication issues |
| [ ]  | Significant Medical/Physical Illness:      | [ ]  | Other:       |
| LIVING ARRANGEMENTS |
| Please check the person’s living arrangements: |
| [ ]  | Self | [ ]  | Spouse/ Partner and others | [ ]  | Children |
| [ ]  | Relatives | [ ]  | Non-Relatives | [ ]  | Unknown/Service Recipient Declined |
| [ ]  | Parents |
| EMPLOYMENT |
| Please check the person’s employment status: |
| [ ]  | Independent/Competitive (Self) | [ ]  | Independent/Competitive (FT) | [ ]  | Assisted / Supportive |
| [ ]  | Sheltered Workshop | [ ]  | Non-Paid work experience | [ ]  | No employment |
| [ ]  | No employment of any kind | [ ]  | Independent / Competitive (PT) | [ ]  | Alternative Business |
| [ ]  | Casual / Sporadic |
| PHARMACY *(if known)* |
| Name: |       | Phone number: |       |
| Address: |       | Fax number: |       |
| REASON FOR REFERRAL |
|       |
| 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 | [ ]  | Document attached |
| Hospital Discharge Summaries | [ ]  | Document attached |
| Psychiatric Hospitalization(s) | [ ]  | Document attached |
| Recent Laboratory Results | [ ]  | Document attached |
| Other Assessments | [ ]  | Document attached |
| Previous Investigation (e.g., ECG, CT/MRI, Echo) | [ ]  | Document attached |
| Medications List | [ ]  | Document attached |
| Fax your referral to Here24/7 at 1-844-437-3329 for processing during regular business hours |
| Completed by:  |       | Position: |       |
| Physician Signature: |       | Billing #: |       |
|  |  |  |  |
| CC: Client Family:       Date:       Referral Source/GP:       Date:       Other:       Date:        |