| 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: | | | | | | | | | | | | | | | | | | | |