Ontario Health

CIO MHA Standardized Referral Form

*** Indicates a required field**

Information for Referring Providers

Central Intake Ontario Mental Health and Addictions (CIO MHA)

- CIO MHA is a provincial initiative to streamline access to services and is led by the Mental Health and Addictions Centre of Excellence (MHA CoE) within Ontario Health (OH).
- CIO MHA is an integrated system that utilizes standardized tools and processes to coordinate equitable and seamless access to appropriate mental health and addiction services and supports for people across their lifespan.
- All funded community and hospital outpatient MHA Services (core services) are in scope.

Central Intake Ontario MHA Hub

- Referrals for mental health and addictions (MHA) services will be sent to CIO MHA Hubs who will receive, review, and distribute referrals based on standardized, predetermined workflows and client preferences. The clinical function of CIO MHA is triage, screening and service matching using standardized clinical tools and resources to determine the type, priority and level of care need of individuals and connect them to the most appropriate MHA services and supports.
- All community and hospital outpatient MHA services (core services) funded by Ontario Health can be accessed through CIO MHA Hubs.
- General information and support on available services and referral status will be provided by CIO MHA Hubs for patients, families, and referring providers.

Referral Process - *** Only completed referrals will be accepted and processed***

- Referring provider submits referral
- Referral reviewed by CIO MHA Hub for completeness and care need
- All referrals triaged by clinicians
- Some referrals may require a screening interview with patient/client to determine care need
- Referral sent to most appropriate service based on care need
- Patient/client contacted for care assessment and care plan

Child & Youth Mental Health

- CIO MHA Hubs will work with Child and youth MHA service providers and establish linkages to manage child and youth mental health referrals.

How to Refer to CIO MHA

- Send completed CIO MHA referral form to your Hub:

Region	Central Intake Ontario MHA Hub	Phone	Fax
Central	Central Intake Ontario Central MHA Hub	905-338-4123	905-338-2878
East	Central Intake Ontario East MHA Hub	833-527-8207	N/A
North East	Central Intake Ontario North East MHA Hub	855-276-6313	705-476-6136
North West	Central Intake Ontario North West MHA Hub	807-624-3400	807-624-3525
Toronto	Central Intake Ontario Toronto MHA Hub	416-535-8501, option 2	855-683-0146
West	Central Intake Ontario West MHA Hub	844-437-3247	844-437-3329

- Please attach all relevant:
  - Consult reports or discharge summaries
  - Laboratory and diagnostic investigations
  - Assessments or patient-reported scales (e.g. PHQ-9, GAD-7)

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Section A: Patient Information*

Surname		**Mobile #:**		**Can leave voicemail** ☐ Yes ☐ No	
First name		**Home #:**			
DOB (YYYY/MM/DD)		**Business #:**			
Gender: ☐ Male ☐ Female ☐ Other		**Email:**			
HN (ON-5555555132-VC):		**Best contact method** ☐ Mobile ☐ Home ☐ Business ☐ Email			
Address:					
	Street Address	Line 2	City/Town	Province	Postal Code

Section B: Additional Patient Information

Sex assigned at birth: ☐ Female ☐ Male ☐ Intersex ☐ Unknown

Pronouns: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Other:

Preferred name:

Preferred language: ☐ English ☐ French ☐ Other (please specify): ☐ Interpreter required

☐ Alternate contact	**Contact name: ***	**Relationship:**
	Alternate Contact Phone #:	

Is Alternate Contact the appointment booking contact? ☐ Yes ☐ No	☐ **Unsafe contact persons (do not speak with):**
	☐ **Only speak with patient directly**

Accessibility Concerns or Disability (Select all that apply)

☐ Falls Risk ☐ Mobility ☐ Hearing ☐ Vision ☐ Other

Details of special considerations:

Section C: Additional Referral Information

☐ Currently followed by a psychiatrist (within past 6 months)	Psychiatrist name:*
	Psychiatrist Phone Number:
☐ Currently receiving support/treatment from any MHA organization/programs/ provider	Please describe:

Triage Considerations

Requested Priority:* ☐ Routine ☐ Urgent (if urgent, provide reason):

☐ Referral for child or youth (<18 years) ☐ Children's Aid Society Involved	Custody Status (e.g. parents together, shared, sole, informal arrangements): *
☐ Currently pregnant or <12 months post-partum	Please describe (e.g. estimated delivery date, birth date, birth site):*
☐ Recent Hospitalization or ER Visit for this issue	Please describe (e.g. date, reason for hospitalization):

Concern(s) / Indication(s) Triggering Referral (Select all that apply) *

☐ Anxiety or Panic Symptoms	☐ Emotional Dysregulation (e.g., anger, aggression, mood swings)
☐ Bipolar / Mania Symptoms	☐ Depressive Symptoms or Low Mood
☐ Obsessions or Compulsions	☐ Difficulty coping with life stressors (e.g. grief, loss)
☐ Behavioural Addictions (e.g., gambling, internet use, gaming, sexual)	☐ Psychotic Symptoms (e.g., hallucinations, delusions, etc.) ☐ First Episode of Psychosis
☐ Trauma-Related Symptoms / PTSD (e.g., hypervigilance, flashbacks)	☐ Personality-Related Concerns (e.g., unstable relationships, chronic conflict with others)
☐ Dementia-Related Behaviours	☐ Substance Use Concerns (specify):
☐ Eating Concerns (restricted or binge eating)	*** Complete Section G if selected**
☐ Other (please specify):	

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Reason for Referral:*

*Clinical Question / Goal(s) of Referral with Relevant History, Management and Investigations**

[Optional] Service(s) Requested (Select all that apply)

Please Note: Central Intake Ontario MHA will match the patient to services using the referral details and, where applicable, contact the patient for any additional information to identify the most appropriate service to meet their care need. The final service match or recommendation may differ from the service selected.

☐ Counselling / Psychotherapy Services	☐ Case Management	☐ Supportive Housing
☐ Stabilization on Opioid Agonist Therapy	☐ Peer Support Services	☐ Family Support Services
☐ Substance Use / Addiction Treatment	☐ Withdrawal Management	☐ Court Support

☐ Bed-based Addiction Services (formerly known as Residential Addictions Services)

☐ Psychiatry Consultation (select all that apply):
☐ Diagnostic Clarification ☐ Medication/Treatment Recommendations ☐ rTMS ☐ ECT

☐ Other Services (please specify):

Section D: Current Risks

☐ Possible Safety Concern to Others (e.g. aggression, homicidal threats or ideation)		☐ Legal Involvement / Court Orders (e.g. current charges, probation, parole, CTO/ORB conditions)	
☐ Suicidal Ideation or Attempt	☐ Self-Harm Behaviours	☐ Housing Instability	☐ Other

If selected, please describe:*

Section E: Medical/Mental Health History

☐ CPP attached ***Please delete any sensitive information you do not intend to share from the CPP***

Past Medical/Mental Health History ☐ Relevant medical history /notes attached	
Current Medications (name, dose, frequency) ☐ List attached	

Section F: Referring Provider Information*

Name:		Role: ☐ Primary Care Provider (PCP) ☐ Other:			
Phone:		Fax:		Billing #:	
Address:					
	Street Address	Line 2	City/Town	Province	Postal Code
PCP Name:		☐ PCP same as referring provider		☐ Patient does NOT have a PCP	

Patient/Client is aware of this referral and has consented to the referral.

SIGNATURE **DATE**

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Section G: Additional Eating Disorders Questions
(only complete if "Eating Disorders" selected above)

Previously received eating disorders treatment ☐ *Yes* ☐ *No*
*(If yes, specify program name and date):**

Current Weight (kgs):*	Current Height (cm):*
BMI:	Lowest Weight (kgs):
Heart Rate:*	Date of Reading (HR/BP):*
Blood Pressure:*	Date of LMP:

Weight Control Methods (Select all that apply) *

	(Please describe (e.g., frequency, duration):
☐ Food Intake Restrictions	
☐ Binge Eating	
☐ Induced Vomiting	
☐ Laxative Use	
☐ Exercise Quantity (per week)	
☐ Chewing and Spitting	
☐ Diet Pills	
☐ Other	

Please attach the following*:

- Growth chart for ≤18 years old, if available
- ECG (within last 30 days)
- Full lab results (within the last 30 days): CBC and Differential, Urea, Creatinine, Sodium, Potassium, Glucose, Calcium, Magnesium, Phosphate, Amylase, Folate, RBC, TSH, ALT, ALP, Bilirubin, GGT, Albumin, Ferritin, Vitamin B12

Need this information in an accessible format? 1-877-280-8538, TTY 1-800-855-0511, info@ontariohealth.ca.
Document disponible en français en contactant info@ontariohealth.ca