# HÔTEL-DIEU GRACE HEALTHCARE
## OUTPATIENT MENTAL HEALTH SERVICES
## CONCURRENT DISORDER PROGRAM
## REFERRAL FORM

*Phone No.: (519) 257-5125 Fax No.: (519) 257-5296*

REFERRAL DATE: _____
Intake Date/Time: _____
Assigned Worker: _____

LAST: _____ FIRST: _____ GENDER:
ADDRESS: _____ CITY: _____ P.C: _____ M or F
PHONE No.: _____ EMERGENCY CONTACT (Name, Relationship & Phone):
D.O.B. (Day-Mon-Year): _____
PHIN: _____ Version: _____

******PHYSICIAN/PSYCHIATRIST INFORMATION REQUIRED (SEE SECTION (16)******

NOTE- INCOMPLETE FORMS WILL BE DIRECTED BACK TO SOURCE

Admission Criteria: Age 16 - 64 yrs of age
Treatment has been attempted but patient has not responded to primary care
Patient with a mental illness who is abusing alcohol or other substance.

FAMILY PHYSICIANS: PLEASE COMPLETE INFORMATION BELOW AND PROVIDE REQUESTED ATTACHMENTS

*PSYCHIATRISTS: 1. PLEASE ALSO COMPLETE PAGE 2*
*2. PROGRAM DOES NOT PROVIDE ONGOING PSYCHIATRIC FOLLOW-UP FOLLOWING DISCHARGE.*

1. Provisional DSM-IV-TR Diagnosis, if available: _____
2. GAF Assessment:
   - [ ] **61-70** Some mild symptoms OR some difficulty in social, occupational, or school functioning; generally functioning well
   - [ ] **51-60** Moderate symptoms OR any moderate difficulty in social, occupational, or school functioning.
   - [ ] **41-50** Serious symptoms OR any serious impairment in social, occupational, or school functioning.
   - [ ] **31-40** Some impairment in reality testing or communication OR major impairment in several areas-work, school, family judgment, thinking, or mood.
   - [ ] **21-30** Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communications or judgment OR inability to function in all areas.
   - [ ] **11-20** Some danger of hurting self or others OR occasionally fails to maintain minimal personal hygiene OR gross

   PLEASE FORWARD ANY LAB RESULTS, CT OR MRI REPORTS OF POTENTIAL RELEVANCE, IF AVAILABLE
3. Duration of Psychiatric Symptoms: [ ] Recently [ ] Duration < 2 years [ ] Duration 2 years or more
   Past Suicidal Behaviour? If yes, plese explain.
4. Current MEDICATIONS: DOSAGE, REASON FOR USE and DATES INITIATED (or attach list) [Psychiatrists- use pg 2]
5. Physical health/conditions:
6. Is patient currently seeing a psychiatrist? If yes, who? _____ Next Appt. Date _____
   If previously, who/when? _____
   (Please forward any psychiatric reports, consultations, discharge reports as applicable)
7. Past PSYCHIATRIC Hospitalizations: [ ] NO [ ] YES - PLEASE INDICATE HOSPITAL AND APPROX DATE
8. Describe nature and extent of patient's substance use. Is patient also compulsive gambler? [ ] No [ ] Yes

   Does patient recognize they have a problem? [ ] NO [ ] YES
9. Current involvement with any other mental health/counselling services? :
10. Any barriers to communication? [ ] NO [ ] YES

## PLEASE ATTACH COPY OF ANY PSYCHIATRIC REPORT COMPLETED IN PAST SEVERAL YEARS.

11. LENGTH OF TIME AS CARE PROVIDER FOR THIS PATIENT: _____

12. PATIENT'S PRIMARY PSYCHIATRIC DIAGNOSIS AND CO-MORBIDITIES (INCLUDING ADDICITONS AND PAIN DISORDERS):

13. WHAT IS THE GOAL OF THIS REFERRAL? WHAT IS IT THAT YOU ARE EXPECTING TO BE ACCOMPLISHED?

14. WHAT MEDICATIONS HAVE BEEN TRIED AND WITH WHAT RESULTS? (IF NOT COMPLETE ON PREVIOUS PAGE)

15. WHAT TYPE OF PSYCHOTHERAPY HAS BEEN TRIED? (INDIVIDUAL, GROUP, SELF-HELP, ETC.)

16 (a). ☐ I AM AGREEABLE TO A 1X CONSULTATION WITH THE PROGRAM PSYCHIATRIST.

☐ I AM AGREEABLE TO HAVING THE PROGRAM PSYCHIATRIST SEE THIS PATIENT FOR THE PROGRAM DURATION, WITH THE UNDERSTANDING THAT TREATMENT CHANGES MAY OCCUR

16 (b).OUR PROGRAM DOES NOT PROVIDE ON-GOING PSYCHIATRY FOLLOW UP UPON PROGRAM COMPLETION AND PATIENT WILL BE RETURNED TO YOUR CARE. ARE YOU AGREEABLE TO THIS? [ ] YES [ ] NO IF NOT, WHY?

REFERRING DOCTOR: _____ FAMILY DOCTOR: _____
ADDRESS: _____ ADDRESS: _____
PHYSICIAN NO.: _____ PHYSICIAN NO.: _____
PHONE: _____ PHONE: _____

REFFERING DOCTOR'S SIGNATURE: _____