NOTE: Incomplete and/or unsigned requisitions will be returned

Markham Stouffville Hospital
Oak Valley Health

Outpatient Mental Health Referral (External)

Adult OPMH Telephone: 905-472-7011
Child & Adolescent OPMH Telephone: 905-472-7530

Please Fax To: 905-472-7371

Patient will be contacted once a completed referral has been received. Treatment approach and duration are at the discretion of the OPMH clinicans and psychiatrists.

- ☐ **Adult OPMH**
- ☐ **Child and Adolescent OPMH**
- ☐ **ATLAS Adolescent Day Hospital Program**
- ☐ **Diagnostic Clarification**
- ☐ **Treatment Recommendations**
- ☐ **Medication Review**

PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

Hospital MRN #: _____

Patient Name : _____
Last First

Date of Birth: _____ Sex: F M
DD/MM/YYYY

Health Card #: _____ Version Code: _____

☐ WSIB # _____ ☐ Non OHIP (Self-pay) or Refugee

Address: _____ Postal Code: _____

Daytime Tel #: _____

Alternate Tel #: _____

Email: _____

Date Referral	**Referred by:** ☐ Family Physician ☐ Psychiatrist ☐ Other	**CPSO #**	**Billing #**
Referring Physician Name		**Physician Tel. #**	**Physician Fax #**
Ref. Physician Address			**Postal Code**
Preferred Language	**Name & number of interpreter to help schedule appointment, if available**		
Next of Kin Name		**Contact #**	**Is patient aware of referral?** ☐ Yes ☐ No
Next of Kin Name		**Contact #**	**Is family aware of referral?** ☐ Yes ☐ No
Does this patient currently have a psychiatrist? ☐ Yes ☐ No	**If yes, name**		**Phone #**

Reason for Referral

Main Diagnosis/Presenting Problem(s)

☐ Depression ☐ Anxiety ☐ Bipolar ☐ Suicidal Ideation ☐ Psychosis ☐ OCD ☐ School refusal ☐ Addictions (Adult)
☐ Complex Mental Health Issues ☐ Other: _____

Medication - Mandatory If incomplete, this referral may be redirected for completion leading to delays in processing.

Please indicate all medication patient is **currently** taking

Medication	Dose	Duration	Comments

Please indicate all medication patient has taken in the **past**

Medication	Dose	Duration	Comments

Risks

Threat to self	☐ Yes	☐ No	When:
Threat to others	☐ Yes	☐ No	When:
Suicidal Ideation	☐ Yes	☐ No	When:
Violent Behaviour	☐ Yes	☐ No	When:

***If there is imminent risk please refer to the emergency department for an assessment**

We do not offer forensic assessment or treatment, MVA assessment, or adult ADHD assessment or treatment.

We are unable to provide assessments for legal, custody, disability, insurance or Workers Compensation issues, please confirm that this is not a referral for such a consultation. Confirmed ☐

_____ _____
Physician Signature Date