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: _____

To avoid delays please ensure all relevant documents are included with referral i.e. psychiatrist reports/discharge summaries, child custody orders, POA for personal care etc. Please confirm relevant documents are included. Confirmed ☐

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 (mandatory, please complete)

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 or attach list

Medication	Dose	Duration	Comments

Please indicate all medication patient has taken in the **past** or attach list

Medication	Dose	Duration	Comments

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

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

We do not offer assessment and treatment of eating disorders, legal assessment for court proceedings (i.e. forensic or family court) parenting/custody assessment, Autism assessment, psychoeducation assessment or assessment for insurance or Workers Compensation issues, or adult ADHD assessment or treatment. Please confirm that this is not a referral for such a consultation. Confirmed ☐

_____ _____
Physician Signature Date