LANARK COUNTY MENTAL HEALTH

Referral Form

Tel: 613-283-2170 / Fax: 613-283-9018

REFERRAL SOURCE

Agency / Source:	Telephone:
	Fax:
Date of Referral (yyyy/mm/dd):	Physician Billing #:

CLIENT INFORMATION

Name:		Preferred Contact #:	Can message be left? ☐ Yes ☐ No
Address:		Alternate Contact #:	Can message be left? ☐ Yes ☐ No
City:	Postal Code:	Substitute Decision Maker:	Contact #:
Date of Birth (yyyy/mm/dd):		Health Card #: V-code:	Exp. Date (yy/mm):

Identification of first language:

☐ English ☐ French ☐ Other: ___________________

☐ **Check here to indicate that we can contact the most appropriate service for your client and redirect the referral.**

Family Physician / Nurse Practitioner (if different from referrer):

Address: Telephone (direct):

REASON FOR REFERRAL / PRESENTING PROBLEMS: ☐ Mental Health Support Services ☐ Psychiatry Consultation

NOTE: REFERRALS FOR PSYCHIATRY MUST INCLUDE THE FOLLOWING _(referrals lacking clinical details will be returned)_

- Bloodwork within the last year including: TSH, CBC, Electrolytes, Creatinine/eGFR, ALP, ALT, Serum B12, RBC folate, and blood levels for any monitored medications. Additionally, if the client is taking an Atypical Antipsychotic: Cholesterol, Fasting Glucose, HbA1c.
- Health Hx and current medications (include Hx of psychotropic medications)
- Health records from any previous psychiatric hospitalizations and/or consults
- Description of ***specific*** clinical questions or concerns for psychiatry and purpose of the referral
- A Consent to Disclose Information Form, signed and dated by the client, indicating consent for Lanark County Mental Health to request information / documentation from previous psychiatric hospitalizations or admissions.

RISK FACTORS				CURRENT SITUATION / HISTORY / DIAGNOSIS			
	Yes	**No**	**Comments**		**Yes**	**No**	**Comments**
Harm To Self				Psychiatric Diagnosis			
Harm To Others				Medications: (attach list)			
Inability To Care For Self				Medical Conditions			
Financially Incapable				Past / Present Involvement with Mental Health Agencies or Other Agencies			
Current Legal Issues							
Other Risk Factors *i.e. pregnancy, gambling, concurrent disorders*							

Referral Taken By: (print name) ______________________________

Referral Taken By: (signature) ______________________________ Date: (yyyy/mm/dd) ____________________

PLEASE NOTE THAT ALL INCOMPLETE REFERRAL FORMS WILL BE RETURNED TO SENDER AND DELAY THE REFERRAL PROCESS

F-29-2019