LANARK COUNTY
MENTAL HEALTH
Listening to Understand

T 613-283-2170
F 613-283-9018

179 Elmsley Street North, Unit 142
Smiths Falls, ON K7A 2H8

REFERRAL FORM

REFERRAL SOURCE

Agency / Source
Telephone
Referring Staff
Fax
Date of Referral
Physician Billing #

CLIENT INFORMATION

Full Name
D.O.B.
Gender
Address
City
Postal Code
Health Card #
V/Code
Expiry

Email
Can electronic message be sent? Yes ☐ No ☐

Cell #
Can electronic message be sent? Yes ☐ No ☐

Preferred Contact #
Can message be left? Yes ☐ No ☐

Alternate Contact #
Can message be left? Yes ☐ No ☐

Identification of first language

☐ English
☐ Other (please specify)
☐ French

☐ 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 Consult

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

CONSENT

Consent for Service ☐ Verbal ☐ Signed *Note: Please append signed consent if applicable.

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); pharmacy; renal function test; liver function test; vitamin B12; pregnancy test (females)
- 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.

Referral Taken By _____

Date _____ Signature _____

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