

CAMH Referral Form

INFORMATION FOR REFERRING PROVIDERS:

- **A physician or nurse practitioner referral** is required for the majority of services at CAMH
- A physician referral is preferred for the following services:
 - Geriatric Mental Health Services (incl. Memory Clinic)
 - Schizophrenia Services (STARS)
- **For Addiction Services**, patients may self-refer by calling Access CAMH at 416 535-8501, press 2, then press 4.
 - If the patient already has a methadone/suboxone provider or an addictions physician, involved in their care, that provider will need to fax the completed CAMH referral form.
- It is preferred that the referral comes from the treating psychiatrist or physician.
- Individuals requiring psycholegal assessments who are referred by the court, legal counsel or other third parties should be referred to the psycholegal clinic. Note there is an alternate referral process for this clinic – details can be found at www.camh.ca

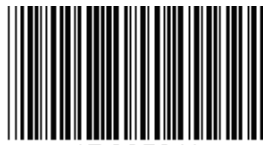
INFORMATION FOR YOUR PATIENT:

- Please ensure your **patient is aware that the referral is being made.**
- **Access CAMH will make two attempts to contact the patient and leave two voicemails**, when consent is provided. If the patient cannot be reached, the referring provider will be notified.
- **Please encourage your patients to call Access CAMH** to check on the status of their referral.
- Given CAMH is an academic research hospital your patient may be invited to participate in research opportunities at CAMH. They do not need to accept.
- Given CAMH is a teaching hospital, your patient can expect to have residents or students involved in their care.

HOW TO SUBMIT A REFERRAL:

- Please fax the completed CAMH referral form to: **416 979-6815**
 - For **Telepsychiatry**, please fax the completed CAMH referral form to: **416 260-4186**
- Please ensure each referral is faxed individually
- To help us provide the best care possible, **include relevant documents**, such as previous psychiatric consultations or discharge summaries, medication sheets, psychological reports, lab and test results, medical reports and physical findings
 - **Please note youth criminal justice documents are not required as part of the referral.** If they are needed, the service will contact the referring provider directly.

If your patient is in need of immediate help, please direct them to the nearest emergency department or call 911.



CAMH REFERRAL FORM

Date of Referral (dd/mm/yyyy): _____

PATIENT INFORMATION

Legal Name First Name: _____ Last Name: _____	Preferred Name (If applicable) _____
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Date of Birth (DD/MM/YYYY): _____	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Trans Woman <input type="checkbox"/> Two-Spirit <input type="checkbox"/> Gender fluid <input type="checkbox"/> Non-binary <input type="checkbox"/> Male <input type="checkbox"/> Trans Man <input type="checkbox"/> Genderqueer <input type="checkbox"/> Androgynous <input type="checkbox"/> Other: _____
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Health Card Information:
 Health Card #: _____ Version Code: _____ Expiration Date (dd/mm/yyyy): _____
 If the patient does not have a Health Card, please provide their Mother's Maiden Name: _____

Patient Address:
 Address: _____
 City: _____ Province: _____ Postal Code: _____ Unit #: _____

Is there a need for an interpreter? Yes No If yes, please specify which language: _____
Are there any accessibility concerns? Yes No If yes, please specify: _____

PATIENT OR DELEGATE CONTACT INFORMATION

By listing telephone numbers or an email address below, the referral source confirms that the patient consents for CAMH to communicate with them via telephone and/or email regarding this referral. CAMH will refrain from communicating unrequired personal information until consents are verified. **Contact information below is for:** Patient Delegate

If Delegate, please specify their name and relationship to patient: _____

Type: _____ **Tel #1:** _____ Consent to voicemail messages: Yes No
Type: _____ **Tel #2:** _____ Consent to voicemail messages: Yes No

E-mail address: _____

CUSTODY STATUS (For youth under the age of 16)

Custody Status:

<input type="checkbox"/> Joint Custody (Please fill out contact information for both guardians)	<input type="checkbox"/> Lives with both parents/ Married/ Common Law (Please fill out contact information for both guardians)	1. Guardian Name: _____ Telephone: _____
<input type="checkbox"/> Sole Custody (Please fill out contact information for the sole guardian)	<input type="checkbox"/> Other (e.g. CAS), please specify: _____	2. Guardian Name: _____ Telephone: _____

REFERRING PROVIDER INFORMATION

Name First Name: _____ Last Name: _____	Please select one of the following: <input type="checkbox"/> Family Physician <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Other: _____ <input type="checkbox"/> Methadone/ Suboxone Provider _____	
Billing Number: _____		
Referring Provider Address: Address: _____ City: _____ Province: _____ Postal Code: _____ Unit #: _____		
Telephone: _____	Fax: _____	Email: _____

Does your patient currently have a psychiatrist? Yes No Unknown
 If yes, please indicate the name of the psychiatrist, First name: _____ Last Name: _____
 If yes, is the patient's current psychiatrist aware of the referral? Yes No
 If no, please indicate why: _____

****If the patient has a psychiatrist it is preferred the referral comes from them. Alternatively, please attach consultation notes****

Patient Name: _____

1. REASON FOR REFERRAL

Please indicate the primary reason for referral (specify current symptoms, presenting problems and history):

Please select the service you're seeking for your patient:

- Psychiatric Consultation
- Diagnostic Clarification
- Treatment Recommendations
- Medication Review
- Specific Treatment (e.g. CBT): _____
- Addictions Treatment
- Other: _____
- None of the above

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2. SUBSTANCE USE (In space below indicate: current substances, amount, frequency of use, etc.)

3. RISKS AND SAFETY CONCERNS

This information is used to optimally plan for the patient's first appointment and to ensure their safety and the safety of our staff.

Risk Issue:	Yes:	No:	If yes, when (DD/MM/YYYY):	Details:
Suicide Attempt/ Ideation	<input type="checkbox"/>	<input type="checkbox"/>		
Deliberate Self-harm	<input type="checkbox"/>	<input type="checkbox"/>		
Violent Behaviour/ Safety Concerns	<input type="checkbox"/>	<input type="checkbox"/>		
Legal Involvement	<input type="checkbox"/>	<input type="checkbox"/>		
Fire Setting	<input type="checkbox"/>	<input type="checkbox"/>		

*****If any of the above risks and safety concerns are selected, you are REQUIRED to provide additional details*****

4. MEDICATION (both psychiatric and non-psychiatric medication)

Medication	Current	Dose	Frequency	Response & Adverse Effects
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			

5. AGENCIES, HOSPITALS OR THERAPIES INVOLVED WITHIN THE PAST TWO YEARS

Organization	Describe Involvement

6. RELEVANT MEDICAL/ DEVELOPMENTAL HISTORY (e.g. disabilities, intellectual delay, autism, allergies, endocrine, neurological, respiratory, cardiac, metabolic or other issues)

Completed by:

Date:

(Print name & credentials)

(signature)

(dd/mm/yyyy)