camh
Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

If you have any questions
about the referral process, please call
Access CAMH at 416 535-8501, press 2

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. **Note the number will appear as a blocked caller ID.**
- **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.

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D0359A

Patient ID Label

(For CAMH use only)

CAMH REFERRAL FORM

Date of Referral (DD/MM/YYYY):_____

PATIENT INFORMATION

Legal Name
First Name: Last Name:

Preferred Name (If applicable)

Date of Birth (DD/MM/YYYY):

Gender:
☐ Female ☐ Trans Woman ☐ Two-Spirit ☐ Gender fluid ☐ Non-binary
☐ Male ☐ Trans Man ☐ Genderqueer ☐ Androgynous ☐ Other: _____

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 call/ email them regarding this referral. CAMH will refrain from communicating unrequired personal information until consents are verified.

Patient/ Delegate Telephone Number(s)/ E-mail Address (Specify type: home, office, cell, etc.)

Contact information below is for: ☐ Patient ☐ Delegate If Delegate, please specify 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:

☐ Joint Custody (Please fill out contact information for both guardians)
☐ Sole Custody (Please fill out contact information for the sole guardian)

☐ Lives with both parents/ Married/ Common Law (Please fill out contact information for both guardians)
☐ Other (e.g. CAS), please specify:
_____

1. Guardian Name:_____
   Telephone: _____
2. Guardian Name: _____
   Telephone: _____

REFERRING PROVIDER INFORMATION

Name
First Name: Last Name:

Billing Number:

Please select one of the following:
☐ Family Physician ☐ Psychiatrist
☐ Nurse Practitioner ☐ Other:
☐ Methadone/ Suboxone Provider _____

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****

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Patient Name: _____

1. REASON FOR REFERRAL

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

** 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 **

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

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

2. SUBSTANCE USE (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:	Yes	No	If yes, when (DD/MM/YYYY):	Details:
Suicide Attempt/ Ideation	☐	☐		
Deliberate Self-harm	☐	☐		
Violent Behaviour/ Safety Concerns	☐	☐		
Legal Involvement	☐	☐		
Fire Setting	☐	☐		

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
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ 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: _____ (Print name & credentials) _____ (signature) Date: _____ (dd/mm/yyyy)

Forms completed electronically should be printed, signed and faxed to CAMH.
Please fax referral to Access CAMH at 416-979-6815
Please review instructions included (also available at camh.ca/referralform)
Website: camh.ca