Huron Health SYSTEM
Alexandra Marine & General Hospital

Huron Health System
PSYCHIATRIST Referral Form

Please note, our service is unable to provide support in an emergency. If your client is experiencing a mental health crisis and requires immediate help, advise them to contact the Huron Perth Helpline and Crisis Response Team at 1-888-829-7484 or go to the nearest emergency department.

*******WE HAVE HAD MULTIPLE RETIREMENTS. ONLY RE-REFER PATIENTS NEEDING IMMEDIATE CARE WHILE WE ADDRESS OUR ACUTE MANPOWER ISSUES*******

All sections of this form must be complete in order to proceed with the referral**.**

ALL OF THE FOLLOWING CRITERIA MUST BE MET PRIOR TO THE REFERRAL BEING ACCEPTED:

- Must be a current resident of HURON COUNTY
- Must be older than 16 years of age
- Primary Care Provider must be willing to provide ongoing follow up

We will provide Consultation and in some cases limited follow up based on clinical situation. We do *NOT* have sufficient staff to provide alternate consultation and follow up for clients wishing to change psychiatrists.

We do *NOT* accept referrals to specific psychiatrists but please indicate if one of our psychiatrists has seen the client previously.

We do ***NOT*** accept referrals for psychotherapy – if provider is looking for psychotherapy please contact Huron Community Mental Health Services at 1-877-695-2524 (for CBT, DBT, Disordered eating etc.)

If substances are the primary issue please contact CMHA Huron-Perth Addiction & Mental Health Services at 1-888-261-9350

I will continue to provide medical care and ongoing follow up ☐ Yes ☐ No

Is patient aware of the referral, if no please explain: ☐ Yes ☐ No

Date:	**Health Card#**	**Version**:

Full Legal Name (on health card): **Preferred name:**	**Gender**: ☐ M ☐ F ☐ Other Preferred pronouns: _____/_____	**Marital Status**:
Mailing Address: **Postal Code**:	**911 Address**: **Email address**: **Birth date**: / / DD / MM / YYYY	**Age**:
Telephone Numbers (Primary): **Messages can be left?** ☐ Yes ☐ No	(Secondary): **Messages can be left?** ☐ Yes ☐ No	
Delegate Contact Info:	**Relationship**:	
Telephone Numbers: **Messages can be left?** ☐ Yes ☐ No		

Fax COMPLETED Referral Form to 519-524-8513

Current safety factors: Assess and check all that apply below and provide details.

☐ Recent Suicide attempt ☐ Active Self-harm behaviour ☐ Violence or aggression

☐ Current Substance abuse ☐ Legal involvement ☐ Psychotic Symptoms

Other:

Details:

Reason for Referral:

Past / Current Involvement with Mental Health Services:

Past Medical History (including relevant investigations):

Medication List & Past Medication Trials:

Supplemental documents, i.e. Psychiatric/Psychological Assessments, Discharge Summaries etc. Attached: ☐ **Yes** ☐ **No**

REFERRAL SOURCE:

NAME: **PHONE #:** **FAX #:**

ADDRESS: **CITY:** **Postal Code:**

☐ Family Physician ☐ Nurse Practitioner ☐ ED Physician/Nurse Practitioner ☐ Walk-In Clinic Physician

☐ Specialist: ______________________________________ ☐ OHIP Billing #: ____

Signature: ____

Fax COMPLETED Referral Form to 519-524-8513