Sunnybrook
HEALTH SCIENCES CENTRE

Mental Health Services

Ambulatory Care Services Referral

Please print and fax referrals to: 416-480-7842

Sunnybrook staff: when faxing referral forms within the hospital, please send faxes to the full 10-digit fax number.

Referral status:
General/Geriatric/Mood phone: 416-480-6833
Neuropsychiatry phone: 416-480-4216
Thompson Centre phone: 416-480-4002

PATIENT IDENTIFICATION

Please note: We do not provide urgent care services. Patients should be directed to their nearest Emergency Department.

For other Department of Psychiatry forms including the Youth Clinic, Women's Mood and Anxiety Clinic, Rapid Access Addiction Medicine Clinic (RAAM), Thompson Centre and Community Psychiatric Services for the Elderly, please visit our website http://sunnybrook.ca/content/?page=dept-psych-help

SPECIFY CLINICAL SERVICE

☐ General assessment (age 19-64)
☐ Mood disorders (depression and bipolar disorders only; service area coverage applies)

Neuropsychiatry:
☐ Multiple Sclerosis Clinic ☐ Acute Traumatic Brain Injury (within 3 months of injury)

☐ Post Trauma Mental Health Clinic (within 1 year - not traumatic brain injury/primary substance use)

Frederick W. Thompson Anxiety Disorders Centre - Choose service:
☐ Psychiatric consultation ☐ MD-to-MD consultation
☐ Group cognitive behavioural therapy ☐ Group mindfulness based cognitive therapy

Area of concern:
☐ Obsessive Compulsive Disorder (OCD): non-severe, non-residential/day program (service area coverage applies)
☐ OCD related spectrum disorders: hoarding, skin-picking, compulsive hair pulling, body dysmorphic disorder.
For patients outside of catchment with severe OCD, please visit www.sunnybrook.ca/thompsoncentre for forms and eligibility criteria

Geriatric (must be over the age of 64; out-patient only; excludes home visits; service area coverage applies):
☐ General assessment
☐ Cognitive behavioural therapy for insomnia in older adults

Neuromodulation:
☐ Repetitive Transcranial Magnetic Stimulation (rTMS)
☐ Electroconvulsive Therapy (ECT)
☐ Deep brain stimulation
☐ Focused ultrasound
Please include primary diagnosis for neuromodulation referral request: _____
(please note referring physicians must remain available to provide non-neuromodulation treatments)

PLEASE NOTE: Patients will be accepted for consultation based on availability of services and place of residence.

PATIENT INFORMATION

Last name:	First name:
Address:	Postal code:
Date of birth (YYYY/MM/DD):	OHIN: Version code:
Patient email:	Patient email consent approved: ☐ Yes ☐ No

Patient phone number: _____
Can a message be left? ☐ Yes ☐ No **OR** ☐ With another person*

*Name of other person:	Relation:	Phone number:

Has this patient been referred to another facility or physician for psychiatric consultation in last 12 months?
If yes, provide name:

Psychiatry admin use only:

DPR60814A

PR 60814
(2022/01/19)

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REFERRING PHYSICIAN INFORMATION	
Physician name:	Billing number:
Address:	Postal code:
Phone number:	Fax number:
Does referring physician or family doctor agree to implement/monitor recommendations and provide ongoing follow-up? ☐ Yes ☐ No	

REASON FOR REFERRAL	
☐ Diagnostic clarification	☐ Treatment recommendations
Details of referral (including target symptoms and goals of treatment):	

MAIN DIAGNOSIS	
☐ Major depressive disorder ☐ Bipolar disorder	☐ Obsessive Compulsive Disorder or ☐ Related disorders ☐ Psychotic disorder (specify):
☐ Anxiety disorder (specify):	☐ Neurocognitive disorder (specify):
☐ Unknown or other (specify):	

Please indicate all medication(s) patient is CURRENTLY taking.

Medication	Dose/Frequency	Route	Duration	Comments	Benefits	Tolerability

Please indicate all psychiatric medication(s) patient has taken in the PAST.

Medication	Dose/Frequency	Route	Duration	Comments	Benefits	Tolerability

If there are additional medications, please attach list with this referral.

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PATIENT IDENTIFICATION

Please indicate any <u>current</u> *or* <u>past</u> psychotherapy patient has received.		☐ Not Applicable
Type:		Duration:
Cognitive behavioural therapy (CBT)	☐ Individual ☐ Group	
Other (specify)	☐ Individual ☐ Group	
CURRENT MEDICAL CONDITIONS:		
Neuroimaging completed (i.e. CT, MRI, SPECT):		Neurocognitive testing completed: ☐ Yes ☐ No
Substance abuse: ☐ Yes ☐ No If yes, specify:		History of violent or aggressive behaviour: ☐ Yes ☐ No Describe:_____

Legend: SPECT - single-photon emission computed tomography

Sunnybrook Health Sciences Centre Mental Health Services
Outpatient Consultation Referral

Has patient been assessed by a psychiatrist or other mental health professional in the past?
Select: ☐ Yes ☐ No

☐ **If yes, please confirm the psychiatrist is aware of the referral.**
It is critical that we receive the previous consultations on your patient in order to provide effective consultation. Please append them to your referral.

As we are unable to provide assessments for legal, insurance or Workers Compensation issues, please confirm that this is not a referral for such a consultation.
☐ Confirmed

Please note: Alternative referral options will be provided to referring physician for all patients not accepted for consultation.

Patient may be notified of their appointment via email.

Name of health care professional submitting this referral (PRINT NAME):_____

Signature: _____ Credentials: _____

Phone number: _____ Date (YYYY/MM/DD): _____