

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

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>

PATIENT IDENTIFICATION

SPECIFY CLINICAL SERVICE	
<input type="checkbox"/> General assessment (age 19-64)	
<input type="checkbox"/> Mood disorders (depression and bipolar disorders only; service area coverage applies)	
Neuropsychiatry:	
<input type="checkbox"/> Multiple Sclerosis Clinic	<input type="checkbox"/> Acute Traumatic Brain Injury (within 3 months of injury)
<input type="checkbox"/> Post Trauma Mental Health Clinic (within 1 year - not traumatic brain injury/primary substance use)	
Frederick W. Thompson Anxiety Disorders Centre - Choose service:	
<input type="checkbox"/> Psychiatric consultation	<input type="checkbox"/> MD-to-MD consultation
<input type="checkbox"/> Group cognitive behavioural therapy	<input type="checkbox"/> Group mindfulness based cognitive therapy
Area of concern:	
<input type="checkbox"/> Obsessive Compulsive Disorder (OCD): non-severe, non-residential/day program (service area coverage applies)	
<input type="checkbox"/> 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):	
<input type="checkbox"/> General assessment	
<input type="checkbox"/> Cognitive behavioural therapy for insomnia in older adults	
Neuromodulation:	
<input type="checkbox"/> Repetitive Transcranial Magnetic Stimulation (rTMS)	
<input type="checkbox"/> Electroconvulsive Therapy (ECT)	
<input type="checkbox"/> Deep brain stimulation	
<input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Patient phone number: _____		
Can a message be left? <input type="checkbox"/> Yes <input type="checkbox"/> No OR <input type="checkbox"/> 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)

Mental Health Services
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PATIENT IDENTIFICATION

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? <input type="checkbox"/> Yes <input type="checkbox"/> No	

REASON FOR REFERRAL	
<input type="checkbox"/> Diagnostic clarification	<input type="checkbox"/> Treatment recommendations
Details of referral (including target symptoms and goals of treatment):	

MAIN DIAGNOSIS	
<input type="checkbox"/> Major depressive disorder	<input type="checkbox"/> Obsessive Compulsive Disorder <u>or</u> <input type="checkbox"/> Related disorders
<input type="checkbox"/> Bipolar disorder	<input type="checkbox"/> Psychotic disorder (specify):
<input type="checkbox"/> Anxiety disorder (specify):	<input type="checkbox"/> Neurocognitive disorder (specify):
<input type="checkbox"/> Unknown or other (specify):	

Please indicate all medication(s) patient is CURRENTLY taking.						
Medication	Dose/Frequency	Route	Duration	Comments	Benefits	Tolerability

Please indicate all <u>psychiatric</u> 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)	<input type="checkbox"/> Individual <input type="checkbox"/> Group	
Other (specify)	<input type="checkbox"/> Individual <input type="checkbox"/> Group	
CURRENT MEDICAL CONDITIONS:		
Neuroimaging completed (i.e. CT, MRI, SPECT):		Neurocognitive testing completed: <input type="checkbox"/> Yes <input type="checkbox"/> No
Substance abuse: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify:		History of violent or aggressive behaviour: <input type="checkbox"/> Yes <input type="checkbox"/> 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): _____

