COLLINGWOOD G&M HOSPITAL

Outpatient Mental Health Referral/Psychiatric Consultation Request

Outpatient Mental Health Services accepts referrals where there is a serious mental illness or a primary psychiatric concern. This referral form is NOT to be used to access crisis services. Referrals that are not appropriate or incomplete will not be processed and all referrals will be screened. **Fax completed referral form to: 705-444-5131**

Psychiatric consultation at OMHS is based upon a shared care model and referrals without a following family physician/nurse practitioner will not be accepted.

Self-referrals for psychotherapy/case management are welcome.

We are not able to accept referrals where the primary concern relates to: Anger management, Chronic pain, Relationship counselling, Autism spectrum disorders, Developmental Delay, Substance Use Disorder, patients under the age of 16 or for patients who live outside of the South Georgian Bay area. Those seeking addiction and/or substance use support can self-refer to the Canadian Mental Health Association by calling 705-444-2558.

We do not provide assessments for: legal, insurance, custody, Family Connexions (CAS), Workplace Safety and Insurance Board (WSIB), Capacity assessments or forensic reasons.

Client/Patient Information: Is Client aware of and agreeable to referral? ☐ Yes **If no please do not proceed with referral**

Last Name: First Name: DOB: _____/_____/____

Gender: ☐Male ☐Female ☐Transgender ☐Intersex ☐Two Spirit ☐Prefer not to answer

Address:

Contact Number: ☐Y ☐N Can Leave Message?

Health Card number: VC

Service(s) requested in this referral

Psychiatric Consultation	Mental Health Program
☐ Diagnostic Clarification	☐ Psychotherapy (ages 16+)
☐ Medication Review	☐ Case Management Program
☐ Short-Term Management	☐ Perinatal Mental Health

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Diagnosis or Psychiatric Presentation:

Risk Issues: ☐ Criminal Charges ☐ Violent Behaviour ☐ Suicide Attempts ☐ Other self-harm behaviour

Current Medications (psychiatric and non-psychiatric): **Please list or attach medication profile**

Medication	Dose/frequency/route

How are medications funded? ☐ ODSP ☐ OBD ☐ Private Insurance ☐ Self Pay

Current Investigations (Blood work, CT scans): Please attach Allergies:

Is the patient currently receiving therapy/treatment? ☐ Yes ☐ No

Referring Source Information:

Referred by: ☐ Physician ☐ Nurse Practitioner ☐ Self ☐ Other

Reason for Referral:

Referring Name: Last First

Signature: _____

OHIP Referral #:

Phone #: Fax #:

Name of Family doctor (if different from referring source): _____