St.Thomas Elgin General Hospital

ADULT MENTAL HEALTH SERVICES REFERRAL

PHONE: (519)637-0511 Fax: (519)631-6497

Date of Referral: _____ MRN#_____

Please note: Our service is not able to provide immediate support in an emergency.
If your patient is experiencing a mental health crisis and requires immediate help – advise them to contact REACH OUT (24 hour crisis line) 1-866-933-2023; or go to their nearest emergency department.
We are unable to provide Independent Medical Evaluations for Court, CAS Assessments; ODSP, WSIB, Forensics or Capacity Assessments.

Patient Information

Last Name:_____ First Name:_____ Age: _____ (***18 years+)**
DOB:(YYYY/MM/DD):_____ OHIP #_____VC:_____
Address: _____City: _____ Postal Code:_____
Home Phone: _____ Cell Phone: _____ Voice Mail OK? Yes ☐

No emailing or texting is available.

If patient has a family doctor or psychiatrist, please consult treating physician prior to referral.
Family Physician:_____ ***Psychiatrist:*** _____

Current Safety Risk Factors (Assess and check all that apply and provide details below)

☐ Active suicidal thoughts ☐ Passive suicidal thoughts ☐ History of suicide attempt
☐ Current intentional self-harm behaviours ☐ Current substance abuse
☐ History of violence/aggression ☐ Thoughts to harm others
☐ Behaviour influenced by delusions/command hallucinations

Reason for Referral and Goals for Treatment (attach relevant notes/assessments, if available)

Current Medications

☐ Current Medication List or Cumulative Patient Profile Attached

Prior Psychiatric Medications: _____

Current Supports and Resources

Referral Source:

Name:_____ Phone #: _____ Fax#: _____
Address:_____ City:_____ Postal Code:_____
☐ Family Physician ☐ Nurse Practitioner ☐ ED Physician ☐ Walk-In-Clinic Physician
☐ Other: _____

Signature: _____

FOR OFFICE USE: Assigned Clinician: Date received: