Niagara Region

Mental Health Referral Form

Niagara Region Mental Health
Public Health

905-688-2854, ext. 7262 Toll free: 1-800-263-7215
niagararegion.ca/health

Please complete and return this form by fax to 905-684-9798.

Patient Label
Health Care Provider Stamp/Label

For requests made to the Early Psychosis Intervention service, an intake worker will contact the client within 72 hours. For all other services, clients will be contacted within 5-7 business days.

If available, the following documents MUST be submitted with the referral:

- Most recent psychiatric consultation report(s)
- List of current medications
- Discharge summary
- Personal safety plan

Please attach bloodwork and consultation notes done within the past 6 months if available.
(i.e, CBC, TSH, electrolytes, glucose, lipids, prolactin, LFT's, Cr, B12 drug levels, CT Scan, EEG, EKG)

Referral source information

Fill out if details are not included in the stamp/label above

Referral source type: Date of referral:

Referral contact name:

Phone and extension: Fax number:

Full address:

Postal code: Billing number:

Client information

Fill out if details are not included in the stamp/label above

First name: Last name:

Date of birth (month/day/year): Health card number:

Address:

City: Postal code:

Phone (home): Phone (cell):

Gender:

Male

Female

Other: ______________________________

Age at onset of mental illness: ____________ Age of first psychiatric hospitalization: ____________

Reason for most recent hospital visit/admission: ____________

Reason for referral:

Psychiatric and medical diagnoses:

Diagnostic category

- Adjustment Disorders
- Anxiety Disorders
- Delirium, Dementia, Amnestic, and Cognitive Disorders
- Developmental Delay
- Disorders of Childhood/ Adolescence
- Dissociative Disorders
- Eating Disorders
- Factitious Disorders
- Impulse Control Disorders Not Elsewhere Classified
- Mental Disorders Due to General Medical Conditions
- Mood Disorders
- Personality Disorders
- Schizophrenia and Other Psychotic Disorders
- Sleep Disorders
- Somatoform Disorders
- Substance Related Disorders
- Unknown or Service Recipient Declined

Risk factors (check all that apply)

- Command hallucinations
- Danger to others
- Danger to self
- Fears consequences
- Homicidal thoughts
- Impulsive behaviour
- Medication compliance
- Poor social support
- Risk of falls
- Self-harm
- Suicide attempts
- Suicidal ideation
- Violent intention
- Willing to accept help
- Substance Use
  Specify: ____________________

Notes:

Service requested

- Assertive community treatment team (ACTT)
- Case management
- Early psychosis intervention
- Geriatrics case management
- Telemedicine
- Youth mental health and addiction service

Note: Niagara Region Mental Health will assess the needs of the patient and determine which service is most appropriate for that individual.

- Client has verbally consented to the disclosure of their personal health information for the purpose of a referral to Niagara Mental Health
- I agree to receive fax and/or email communication about this referral from Niagara Region Mental Health