Southeast Ontario Addictions & Mental Health Services Access Form
AMHS-KFLA

This form is to be completed by Primary Health Care and other Health Services Providers

FIELDS MARKED WITH AN * ARE CONSIDERED MANDATORY AND MUST BE COMPLETED OR
REFERRAL WILL BE RETURNED AS INCOMPLETE
A GP or NP GENERATED REFERRAL FORM THAT CAPTURES ALL OF THE MANDATORY DATA WILL BE ACCEPTED

Telephone: 613-544-1356 or 613-354-7521 Fax: 613-544-2346

CLIENT INFORMATION

***Name**:

***Gender**:

***Address**:

***Telephone** (home):

***Email Address**:

***Date of Birth**: / /
dd mm yyyy

***Health Card # & V.C**.:

(or affix label above)

***BEST way to contact patient/client:**

Phone ☐ **Text** ☐ **Email** ☐ **Mail** ☐

***Alternate contact person:**

*Name:

*Relationship:

*Phone #:

***Can a detailed message be left? Y** ☐ N ☐

Substitute Decision Maker (personal health):

Name:

Address:

Telephone Number:

Date of Referral: / /
dd mm yyyy

SERVICES

What service(s) would you like your patient / client assessed for?

☐ **Psychiatry** (***PHYSICIAN and NP REFERRALS ONLY**)

***Physician/NP Name:**

***Physician/NP Billing #**:

***Address:**

***Phone:**

***Fax:**

☐ **Mental Health Support Services**
☐ **Addiction Support Services**
☐ **Clinical Counselling**
☐ **Housing**
☐ **Vocational**
☐ **Gambling**
☐ **Eating Disorder**
☐ **Other:**

REFERRAL AGENT INFORMATION (if other than Physician or NP)

***Agency / Source**:

***Contact Person**:

***Telephone**:

***Fax**:

What is your patient's mother tongue?

English ☐ French ☐ Neither ☐

Interpreter Required? **Y** ☐ N ☐

If neither, in which of Canada's official languages is your patient most comfortable using? Receiving health care services in?

English ☐ French ☐

REASON FOR THE REFERRAL: (How can we help?)

PLEASE ATTACH ANY RELEVANT INFO (Psych Notes, Meds etc.)

RISK FACTORS		
	√	**COMMENTS**
***HARM TO SELF:** (current ideation**, past attempts) **refer immediately to Crisis if serious current ideation	☐	
***HARM TO OTHERS:** (ideation, recent or past episodes) **refer immediately to Crisis if serious current ideation	☐	
INABILITY TO CARE FOR SELF: (difficulty meeting own needs i.e. food, shelter, safety, financially incapable)	☐	
***LEGAL ISSUES** (Charges, Court Matters, Probation) **Incl. hx of legal issues	☐	
***SUBSTANCE USE** **Incl. hx of substance use	☐	
MEDICAL CONDITIONS or CHRONIC ILLNESS	☐	

PSYCHIATRIC DIAGNOSIS(ES)

☐ **ANXIETY** ☐ **DEPRESSION** ☐ **SCHIZOPHRENIA** ☐ **PERSONALITY DISORDER**

☐ **BI-POLAR DISORDER** ☐ **DUAL DIAGNOSIS (Intellectual Disability & Mental Illness)**

☐ **OTHER:**

☐ **TREATMENT REFRACTORY DEPRESSION:**
(HAS BEEN TREATED W/AT LEAST 2 MEDICATIONS, W/O SUCCESS, EXPLAIN IN COMMENTS)

COMMENTS:

MEDICATIONS:	☐	**DO NOT LIST – PLEASE ATTACH A LIST**

PLEASE NOTE:

*Limited consent was obtained i.e.: some information was withheld/declined by the client Y ☐ N ☐

☐ *Check here to acknowledge that this referral has been reviewed with the patient/client and that they are aware that they will be contacted and their needs assessed by one of the above agencies and referred on to the most appropriate service

☐ *Check here to indicate that any relevant assessments / consultation reports and / or discharge summaries have been sent with the referral

Completed By (Print Name): ***Signature:**	**Date:** / / dd mm yyyy

***PHYSICIAN or NP SIGNATURE (**required for all Physician and NP referrals**)**