MATAWA HEALTH CO-OPERATIVE

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www.matawa.on.ca/corporations/matawa-health-co-operative/

PSYCHIATRY REFERRAL FORM

☐ Client aware of referral ☐ Consent Forms Attached ☐ Verbal consent given

REFERRAL INFOMATION

*** Physicians and Nurse Practitioners only can refer.**
*** Referrals for External non indigenous population can not be accepted.**
*** Age population: Up to and including 25 years of age.**
*** Can not accommodate addictions system navigation.**

REFERRING PROVIDER INFORMATION * Physicians/Nurse Practitioners ONLY can refer *

Date:	Name of Referrer:
Phone:	Email:

CLIENT INFORMATION

Last Name:	First Name:		Preferred Name:
D.O.B(DD/MM/YYYY):	Age:	Sex:	Pronouns:
Health Card Number:		Primary Phone Number:	
Alternate Phone Number:		Email:	
Community/First Nation(if applicable):			Status Number:

☐Living in Community ☐ Living in Thunder Bay

GUARDIAN/ APPOINTED DECISION MAKER INFORMATION

Name:	Relationship:
Phone Number:	Email:

EMERGENCY CONTACT

Name:	Relationship:
Phone Number:	Email:

PRIMARY CARE PROVIDER INFORMATION

Primary Care Provider Name:	Office Name:
Phone Number:	

REASON FOR REFERRAL

☐ Diagnostic Clarification ☐ Medication Assessment/Review
☐ Shared Care/Ongoing Management ☐ Second Opinion

PRESENTING SYMPTOMS AND HISTORY

Provide details on duration, severity, and functional impairment

SAFETY AND RISK ASSESSMENT

Does the client have an active risk of:				
	Suicidal Ideation/Plan:	☐ No	☐ Past History	☐ Active/Current
	Self-Harm/Cutting:	☐ No	☐ Past History	☐ Active/Current
	Harm to Others/Violence:	☐ No	☐ Past History	☐ Active/Current

**** Note: If the client is in acute, life-threatening crisis, please direct them to the nearest Emergency Department****

MEDICAL HISTORY

Current Medications:	
Past Psychiatric Medication Trials:	
Substance Use:	
Medical Conditions:	
Vitals:	

*ATTACHEMENTS * Please ensure to include hard copies**

☐ Recent Lab Work (e.g CBC, TSH, Electrolytes, Metabolic Panel and UDS)

☐ Most recent ECG

☐ Previous Psychiatric and/or Psychological Assessments

**** Note: below must be completed prior to referral being sent/accepted****

Completed Screening Scales
(Only those required for relevant clinical question)

- ☐ PHQ9(depression)
- ☐ GAD7 (anxiety)
- ☐ PCL5 (PTSD,trauma)
- ☐ SNAP-IV or CADDRA(ADHD; children and youth)
- ☐ ASRS-V1.1 (ADHD; adults)
- ☐ Report cards (ADHD; all available before 12 years-old, required for all age groups)
- ☐ MDQ (bipolar disorder)
- ☐ YBOCS (OCD)