



William Osler  
Health System

**Outpatient Mental Health  
(Centralized Intake and Triage)**  
REFERRAL FORM

**Brampton Civic Hospital  
Etobicoke General Hospital  
Peel Memorial Centre  
Community Mental Health Team**  
Phone: 905-494-6709  
Fax: 905-494-6757

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| <b>Patient Identification</b> |
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**Service Information**

**Referral Source**     ER/ UCC     Acute Care     Primary Health Care     Other \_\_\_\_\_

William Osler Outpatient Mental Health offers short term psychiatric consultation, group psychotherapy, and limited short term individual psychotherapy for patients with mental health concerns. Services may be offered at the Brampton Civic Hospital, Etobicoke General Hospital, Peel Memorial Centre, or Queen Square Family Health Team's Community Mental Health Team.

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| <p><b>INCLUSION CRITERIA</b></p> <ul style="list-style-type: none"> <li>• Resides in Central West LHIN</li> <li>• Provisional diagnosis of mental illness</li> </ul> | <p><b>EXCLUSION CRITERIA</b></p> <ul style="list-style-type: none"> <li>• Actively suicidal or homicidal</li> <li>• Requiring crisis assessment or hospital admission</li> <li>• Assessments for court purposes or forensic psychiatry</li> <li>• Completion of forms for insurance or medical purposes</li> </ul> |
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**Patient Information**

**Patient's Last Name:** \_\_\_\_\_ **Patient's First Name:** \_\_\_\_\_

**Date of Birth: (DD/MM/YY)** \_\_\_\_\_ **Gender:**  Male  Female  Other

**Health Card Number:** \_\_\_\_\_ **Version:** \_\_\_\_\_ **No OHIP:**

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **Province:** \_\_\_\_\_ **Postal Code:** \_\_\_\_\_

**Phone # (primary):** \_\_\_\_\_ **Phone # (alternate):** \_\_\_\_\_ **Cell #:** \_\_\_\_\_

**Patient's E-mail:** \_\_\_\_\_  **Interpretation Services Required; Language:** \_\_\_\_\_

**Person to contact for booking appointment (If different than patient):** \_\_\_\_\_

**Relationship to patient:** \_\_\_\_\_

**Can a message be left on the phone number provided?**  Yes  No

**If the patient is a child, who has parental custody/guardianship?** \_\_\_\_\_

**Reason for Referral & Relevant Patient History**

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| <p><b>URGENCY</b></p> <p><input type="checkbox"/> Urgent</p> <p><input type="checkbox"/> Routine (within 6 weeks)</p> <p><b>AGE RANGE</b></p> <p><input type="checkbox"/> Child (&lt;18)      <input type="checkbox"/> Adult</p> <p><b>Reason for referral:</b></p> <p><input type="checkbox"/> Psychiatry Consult</p> <p><input type="checkbox"/> Mood &amp; Anxiety Psychotherapy Program (Stepped Care Program)</p> <p><input type="checkbox"/> Psychosis Program (inc. Depot/Clozapine)</p> <p><input type="checkbox"/> Eating Disorders Clinic</p> | <p><b>Presenting Problem/Provisional Diagnosis:</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>Current Medications:</b></p> <p>_____</p> <p>_____</p> <p>_____</p> |
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**Referring Physician/Nurse Practitioner (NP) Information**

**Referring Physician/NP Name:** \_\_\_\_\_ **OHIP Billing Number:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_ **Fax #:** \_\_\_\_\_ **E-mail:** \_\_\_\_\_

**Family Physician/NP (If different from above):** \_\_\_\_\_

**Signature of Referring Physician/NP:** \_\_\_\_\_ **Referral Date:** \_\_\_\_\_

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| <p><b>Clinic Use Only</b></p> <p>Date Referral Screened: _____</p> <p>Date Appt. Booked: _____</p> <p>Date of Appt.: _____</p> | <p><b>Referral Received Actions:</b></p> <p><input type="checkbox"/> Approved</p> <p><input type="checkbox"/> Patient Refused</p> <p><input type="checkbox"/> Redirected to _____</p> <p><input type="checkbox"/> Other _____</p> |
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