Centralized Psychiatric Consultation Service for Adults

Referral Form

Fax: 204-940-6681 DATE: ☐☐ ☐☐☐ ☐☐☐☐ (D D M M M Y Y Y Y)

- **Please consider calling the RACE line (Rapid Access to Consultative Expertise) 204-940-2573 for same-day phone advice from a psychiatry consultant prior to referring your patient.**
- **PRINT CLEARLY – INCOMPLETE/ILLEGIBLE FORMS WILL BE RETURNED TO REFERRAL SOURCE**
- **The Centralized Psychiatric Consultation Service:**
  - **Receives and triages referrals for non-urgent outpatient psychiatric assessment**
  - **Provides consultation service for patients over the age of 18 who live within the WRHA catchment area**
  - **Provides assessment and treatment recommendations to the Primary Care Provider**
  - **Requests all pertinent health records be provided at the time of referral**
  - **Does not provide 3rd party assessments for the purpose of insurance, court, custody, etc.**

PATIENT CONTACT INFORMATION

Patient Name: ____________________ Date of Birth: ☐☐ ☐☐☐ ☐☐☐☐ (D D M M M Y Y Y Y)

Patient Address: ____________________

Health Card Number: ☐☐☐☐☐☐ PHIN: ☐☐☐☐☐☐☐☐☐

Primary Phone: ☐☐☐-☐☐☐-☐☐☐☐ Secondary Phone: ☐☐☐-☐☐☐-☐☐☐☐

Primary Language: ____________________ Is interpreter required? ☐ No ☐ Yes

IS PATIENT AWARE OF REFERRAL? ☐ No ☐ Yes

WHAT IS THE PURPOSE OF THE ASSESSMENT?
☐ Diagnostic clarification
☐ Treatment recommendations
☐ Other ____________________

WHAT PROBLEMS/SYMPTOMS IS THE PATIENT HAVING NOW THAT REQUIRE ASSESSMENT?
____
____
____

CURRENT MENTAL HEALTH CONCERNS
☐ Anxiety ☐ Depression ☐ Racing Thoughts ☐ Paranoia ☐ Compulsive Behaviours
☐ Trouble Concentrating ☐ Unstable Relationships ☐ Trauma ☐ Sudden Emotional Changes ☐ Other
Aggressive Behaviours Towards: ☐ Self ☐ Others ☐ Property

Is your patient having suicidal/self-harm thoughts ☐ **No** ☐ **Yes** **Suicidal/Self-harm thoughts in the past month** ☐ **No** ☐ **Yes**
Has your patient made a previous suicide attempt? ☐ **No** ☐ **Yes** ☐☐ ☐☐☐ ☐☐☐☐ (D D M M M Y Y Y Y)
IF THE PATIENT HAS SUICIDAL/SELF-HARM THOUGHTS, ENSURE THAT THIS IS ASSESSED APPROPRIATELY AND ACCESS EMERGENCY/CRISIS RESOURCES AS NEEDED
Is your patient pregnant or postpartum? ☐ **No** ☐ **Yes** Estimated Date of Confinement or Delivery Date ☐☐ ☐☐☐ ☐☐☐☐ (D D M M M Y Y Y Y)

SUBSTANCE USE HISTORY ☐ No ☐ Yes
☐ Alcohol ☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Crystal Methamphetamine
☐ Misuse of Other Prescription Drugs ☐ Illicit Methadone ☐ Misuse of Over The Counter Medication
☐ Other: ____________________
Date last used: ☐☐ ☐☐☐ ☐☐☐☐ (D D M M M Y Y Y Y)
Has this patient sought help with their substance use ☐ No ☐ Yes (explain) ____________________
Does this patient want help with their substance use ☐ No ☐ Yes

Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg
Caring for Health | À l'écoute de notre santé

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TREATMENT HISTORY

Current medications: ______________________

Previous medications tried: ______________________

Psychotherapeutic strategies (Cognitive-Behavioral Therapy, supportive counseling, etc.) ______________________

Records MUST be provided at time of referral. Please provide any pertinent records you have on file (discharge summaries, previous assessments) or consider requesting them with your patient's consent.

☐ No previous psychiatric diagnosis ☐ Previous psychiatric hospitalization at: ______________________

☐ Previous mental health contact *(explain)* ______________________

☐ Current or previous psychiatric diagnosis *(explain)* ______________________

☐ Current mental health supports *(Psychiatrist, Psychologist, Community Mental Health Worker, Therapist, etc.)* ______________________

____

RELEVANT MEDICAL/DEVELOPMENTAL HISTORY (e.g. disabilities, autism, allergies, endocrine, neurological, respiratory, cardiac, metabolic or other issues)

INTELLECTUAL DELAY/COGNITIVE IMPAIRMENT (provide all relevant testing and documentation) ☐ No ☐ Yes

BRAIN/HEAD INJURY (provide all relevant testing and documentation) ☐ No ☐ Yes

LEGAL CHARGES/INVOLVEMENT

☐ No ☐ Yes Please Describe ______________________

LIVING SITUATION

☐ Stable ☐ Unstable ☐ Alone ☐ With Family/Partner/Other

☐ Assisted Living ☐ Group Home ☐ Homeless ☐ Shelter ☐ Other: ______________________

FINANCIAL SITUATION

☐ Employed ☐ Unemployed ☐ Disability Income ☐ Employment and Income Assistance ☐ Self-Supported ☐ Student

OTHER PERTINENT INFORMATION (family history of mental health issues, family issues, other stressors)

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____

REFERRING PRIMARY CARE PROVIDER

Name: ______________________ Phone: ___-___-____

Clinic Name/Address: ______________________ Fax: ___-___-____

As the referring Primary Care Provider, I hereby commit to follow this patient in the community.

______________________ Date: D D M M M Y Y Y Y

SIGNATURE OF REFERRING PRIMARY CARE PROVIDER