

Referral Source Information

Date of Request (DD/MM/YY)

Referring ER Physician

Physician's Provider #

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☐
☐
☐
☐

RVH

CGMH

GBGH

MAHC

OSMH

Phone #

Fax #

Patient Information (Place label here if applicable)

Patient Name

Street Address

City, Province

Postal Code

Date of Birth (DD/MM/YYYY)

Sex

Health Insurance#

Home Phone #

Cell Phone

Patient's current location:

☐ Home

☐ Other: _____

Parent/Caregiver Information

(Please fill in as much as possible)

Name

Relation

Street Address

Email

Home Phone #

Cell Phone

Reason for Referral

(Please be as specific as possible)

Contributing Factors:

Yes No

Inability to care for self

☐
☐

Medication review and stabilization

☐
☐

Diagnostic clarification

☐
☐

Involvement with criminal justice system

☐
☐

Poor functioning in community

☐
☐

Substance misuse

☐
☐

Threat or danger to self

☐
☐

Threat or danger to others

☐
☐

Symptoms of mood

☐
☐

Symptoms of anxiety

☐
☐

Symptoms of psychosis

☐
☐

Signs of cognitive impairment

☐
☐

Trigger – peer or parent conflict

☐
☐

Previous Psychiatric Treatment:

Facility

Notes on treatment: _____

Notice

Please complete the referral form in full and include a copy of the Emergency Department face sheet or record.

If your referral is not appropriate for the UCC we will follow up and contact you.

If you have questions about our referral criteria, please see page two of the referral package.

Please instruct patients to arrive 15 minutes before their appointment in order to complete screening questionnaires.



Referral Guidelines:

*The Urgent Consult Clinic provides a **RISK ASSESSMENT** for patients in urgent need of mental health care. The clinic is unable to accept patients without a referral and will not provide a psychiatric diagnosis.*

Low Risk Criteria (UCC Referral):

Low intent, low lethality – e.g. overdose with no medical attention needed, cutting, informed someone of plan.

Trigger – conflict with parents or peers

Substance use

Future orientation – i.e. able to define future goals and reasons for living.

RVH: You must fax the referral to confirm the appointment. The Urgent Consult Clinic will screen and follow up with inappropriate referrals.

GBGH, CGMH, MAHC & OSMH: You must fax the referral to have the appointment booked by the clinic. The Urgent Consult Clinic will screen and follow up with inappropriate referrals.

