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Referral for Ambulatory Mental Health and Addictions Services – Interventional Psychiatry Program

Location: St. Michael's Hospital, 30 Bond Street, 17 Cardinal Carter South
Toronto, ON M5B 1W8
Phone: 416-864-5120 Fax: 416-864-5480

INFORMATION FOR REFERRING PROVIDERS:

- **A physician or nurse practitioner referral is required** (self-referral is not accepted)
- It is preferred that the referral comes from the treating psychiatrist or physician
- The referring physician **must accept care after patient has completed time-limited treatments offered within the Interventional Psychiatry Program**
- This program is not catchment specific
- This referral form is for the Interventional Psychiatry Program only – for all other referrals, please use the general SMH referral form for Ambulatory Mental Health and Addictions Services, which can be found on the St. Michael's Hospital website.

INFORMATION FOR YOUR PATIENT:

- Please ensure that your patient consents to the referral being made
- Please ensure that your patient is aware that services are time-limited
- Our intake team will make two attempts to contact the patient and leave two voicemails, when consent is provided. If the patient cannot be reached, the referring provider will be notified. Please note that the number will appear as a blocked caller ID.
- Given SMH is a teaching hospital, your patient can expect to have residents or other learners involved in their care.
- Given SMH is an academic research hospital, your patient may be invited to participate in research opportunities. They do not need to accept.
- If eligible, some treatments will require an escort to accompany the patient home after treatment sessions. Please note that the patient will have to arrange this.

PLEASE NOTE THE FOLLOWING CRITERIA:

Referral will not be accepted if the following criteria are not met

- ☐ Referring physician agrees to accept patient back upon completion of time-limited treatments
- ☐ Patient accepts that treatment and services are time-limited
- ☐ Patient is 18 years of age or older
- ☐ Patient has tried at least one or more guideline concordant psychotropic medication trials and at least one or more guideline concordant psychotherapeutic trials

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REFERRING PHYSICIAN'S INFORMATION

Physician's Name: Billing #:
Family Doctor: Specialist (specify):
Address: Postal Code:
Tel: Fax: Email:

Does your patient currently have a psychiatrist? ☐ Yes ☐ No ☐ Unknown
☐ I am the treating psychiatrist
If you are not the treating psychiatrist, please indicate the name of the psychiatrist (if applicable):
First name: Last name:

If you are not the treating psychiatrist, please confirm that the treating psychiatrist is aware of referral:
☐ Yes ☐ No If no, explain why:

PATIENT INFORMATION

☐ Consent to referral ☐ Patient informed services are time-limited

Legal name: _____ Preferred name if applicable: _____
Last First

Date of birth: _____ Gender: _____

Address: _____

Postal code: _____ Health Card Number: _____ Version Code: ____

Telephone number: _____ Alternate phone number: _____

Consent to leave voicemail: ☐ Yes ☐ No With another person: ☐ Yes ☐ No

If your patient would like to use email for appt, scheduling, indicate the following has been done:

☐ Reviewed SMH email consent with patient ☐ Included signed consent with referral

Email address: _____

PLEASE SELECT SERVICE THIS REFERRAL IS INDICATED FOR (you may choose more than one):

- ☐ Repetitive transcranial magnetic stimulation
- ☐ IV Ketamine treatment
- ☐ Electroconvulsive therapy
- ☐ Other experimental treatments (please specify)_____

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REASON FOR REFERRAL:

Please indicate primary reason for referral, current symptoms, and provide details of previous treatments:

Please consider completing two short screening tools available on our referral information website:

PHQ-9 score: GAD-7 score: CSSS score:

PAST PSYCHIATRIC HISTORY (please in most recent consultation, discharge summary or note):

PAST MEDICATION TRIALS (alternatively, you may attach a list of previous medications):

Medication	Dose	Date	Outcome

PAST NEUROSTIMULATION AND/OR EXPERIMENTAL TREATMENT TRIALS:

Please select all relevant trials and include details (date, duration, outcome)

☐ Repetitive Transcranial Magnetic Stimulation _____
☐ Electroconvulsive Therapy _____
☐ Deep Brain Stimulation _____
☐ Other (please specify) _____

PREVIOUS PSYCHOTHERAPY TRIALS

Please select all relevant trials and include details (date, duration, outcome)

☐ Cognitive Behavioural Therapy_____
☐ Dialectical Behaviour Therapy _____
☐ Interpersonal Therapy _____
☐ Mindfulness Based Therapy _____
☐ Cognitive Processing Therapy _____
☐ Psychodynamic Therapy _____

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CURRENT MEDICATIONS (List ALL medications including DOSE and FREQUENCY):

Medication	Dose	Date	Outcome

ALLERGIES:

MEDICAL HISTORY (Please include relevant reports or attach patient profile summary):

SUBSTANCE USE (Please indicate current substances, amount, frequency of use, etc.)

Is there any active substance use in the last 3 months? ☐ Yes ☐ No

Is there a history of substance use disorder? : ☐ Yes ☐ No

If yes, please describe:

RISKS AND SAFETY CONCERNS

This information is used to optimally plan for the patient's first appointment and to ensure their safety and the safety of our staff.

RISK ISSUES	PRESENT		PAST		DETAILS
	Y	N	Y	N	
Criminal Charges					
Violent Behaviour					
Suicide Attempts					
Other Self Harm Behaviour					

AGENCIES, MENTAL HEALTH THERAPIES OR HOSPITALIZATIONS FROM THE LAST TWO YEARS:

Signature: _____ **Date of referral:** _____

Name and designation (print): _____ **CPSO #:** _____

Please note that forms that are incomplete or not clearly printed will be returned.