Sinai Health | Mount Sinai Hospital
Joseph & Wolf Lebovic Health Complex

Department of Psychiatry
Medical Psychiatry Outpatient Clinic Referral Form

Please read before completing/submitting the referral form

MEDICAL PSYCHIATRY (INCLUDING TRANSITIONAL AGED YOUTH) CLINIC REFERRAL
Instructions and Information

FAX TO: 416-586-8654 **INQUIRIES: 416-586-4800 ext. 8493**

The Medical Psychiatry Clinic will see patients followed by a Sinai Health specialist who requires psychiatric consultation. Within the clinic, those aged 18 to 30 will be served by the Transitional Aged Youth stream.

Please review the following information with your patient:

The Department of Psychiatry makes decisions regarding care based on balancing needs, availability of resources and patient preference. Care may include psychiatric consultation, psychosocial assessment, and time limited treatment interventions. Please note: Not all patients will be seen by a psychiatrist, and emphasis will be on providing episodes of care.

To ensure access to all patients, we are not able to provide assessments for patients who have been assessed or treated by a psychiatrist in Ontario in the last year. These patients should be directed to the practitioner who has been involved in their care.

The Clinic does not offer psychiatric assessments for legal, insurance, custody, CAS, WSIB or forensic reasons.

This form is not for individuals experiencing crisis.
Patients experiencing a mental health or addiction emergency should be directed to the nearest emergency department.

Referral Process: Please ensure the patient is aware of this referral. Within two weeks, patients will receive a letter acknowledging the referral. A telephone intake with the patient may be scheduled to gather more information and determine the next step. Intake staff will make **two** attempts to reach the patient and will leave two voice mail messages if available. The number will appear as Sinai Health. If we are unable to reach the patient, the referral source will be notified by fax and the referral form may be inactivated.

Patients are welcome to contact us directly at 416-586-4800 ext. 8493 to discuss their referral at any time.

How to submit a referral:

- Review the above information with the patient to ensure expectations are aligned
- Fax the completed form to 416-586-8654
    - *Please Note: All fields must be completed. If a field is not applicable, please enter 'n/a'. Incomplete forms will be returned to the referral source*
- Fax each referral form individually
- To help us provide the best care, please include all relevant documents including previous psychiatric consultations or discharge summaries, psychological reports, medication sheets, medical reports, lab and test results

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MEDICAL PSYCHIATRY OUTPATIENT CLINIC REFERRAL

FAX TO: 416-586-8654 INQUIRIES: 416-586-4800 ext. 8493

Patient Information

Last Name: _____ First Name: _____

Preferred Name: _____ Pronouns: _____

Health Card#: _____ Version Code: _____

MRN: _____ Birthdate: _____ Age: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Considerations:

☐ Cognitive Impairment ☐ Hearing Impairment ☐ Sight Impairment ☐ Age 65 +

☐ Language Barrier and Interpretation Requested. Please specify language: _____

☐ Other:

Contact Information

Patient consents for Sinai Health to call/email them regarding this referral and appointment booking? ☐ yes ☐ no

Phone: _____ **Consent to leave message:** ☐ yes ☐ no

Email: _____

Alternate Contact

Patient consents for Sinai Health to call/email their alternate contact regarding this referral and appointment booking? ☐ yes ☐ no

Name: _____ Relationship: _____

Phone: _____ Email: _____

Referral Source Information

Name: _____ ☐ MD ☐ NP Billing #: _____

Address: _____

Signature: _____

Phone: _____ Fax: _____

Primary Care Provider: _____ Phone: _____

Medical/Surgical Specialist at Sinai Health: _____ Phone: _____

Has patient been assessed by a psychiatrist in the past? ☐ yes ☐ no *(If yes, please attach consultation)*

If yes, when was the most recent assessment: _____

Has patient been assessed by a psychiatrist at Sinai Health in the past? ☐ yes ☐ no

Reason for Referral

Primary psychiatric concern/clinical question:

Please check all that apply:

☐ Diagnostic Clarification ☐ Treatment Recommendations ☐ MD to MD Telephone Consultation

PHQ-9 and GAD-7 score required for ALL mood and anxiety referrals: www.phqscreeners.com/select-screener

Risk & Safety

Please include ALL current and past behaviours

☐ Violence ☐ Agitation ☐ Self Harm ☐ Suicide attempt ☐ Suicidal ideation

Details:

Current & Past History

Please check ALL that apply and attach relevant notes/consults

☐ Anxiety ☐ Depression ☐ Bipolar Disorder ☐ Trauma Symptoms / PTSD ☐ ADHD

☐ Substance Use Concerns ☐ Psychosis ☐ Cognitive Decline/Confusion ☐ Eating Disorder

☐ Obsessive Compulsive Disorder

☐ Other _____

Details:

Mental Health & Addictions Treatment – Past and Present

Therapies, hospitalizations & community agency involvement

Details:

Medical History

Please attach relevant clinical and medical documentation

Details:

Has the patient been diagnosed with HIV? ☐ Yes ☐ No

Medication History

Please list all current medications (psychiatric and non-psychiatric) and past psychiatric medications (if available) – attach list if necessary

Allergies:

Medication Name	Current	Dose	Frequency	Response & Adverse Effects
____________	☐ yes ☐ no	______	______	______________
____________	☐ yes ☐ no	______	______	______________
____________	☐ yes ☐ no	______	______	______________
____________	☐ yes ☐ no	______	______	______________
____________	☐ yes ☐ no	______	______	______________
____________	☐ yes ☐ no	______	______	______________
____________	☐ yes ☐ no	______	______	______________
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____________	☐ yes ☐ no	______	______	______________
____________	☐ yes ☐ no	______	______	______________
____________	☐ yes ☐ no	______	______	______________
____________	☐ yes ☐ no	______	______	______________