camh

Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

REFERRAL FORM
SCHIZOPHRENIA PROGRAM

addressograph

Client/Patient Name: ______________________ Health Record #: __________

Date of Referral: ______________ (dd/mm/yyyy) Date of Birth: ______________ (dd/mm/yyyy)

Address: ______________________ Telephone: ______________________

____

Health Card #: ______________ Version Code: ________ Date of Expiry: __________

Can confidential message be left on voice mail? ☐ Yes ☐ No

Can confidential message be left with others? ☐ Yes ☐ No

REFERRAL SOURCE:

Name: ______________________ Agency: ______________________

Address: ______________________ Telephone: ______________________

______________________ Fax: ______________________

Attending Physician: ______________________ Physician Billing #: ______________________

Address: ______________________ Telephone: ______________________

______________________ Fax: ______________________

REASON FOR REFERRAL (*Please check one or more of the following*):

First Episode Division:

Fax No. 416-260-4197 **(Tel. No. 416-535-8501, ext. 6528)**

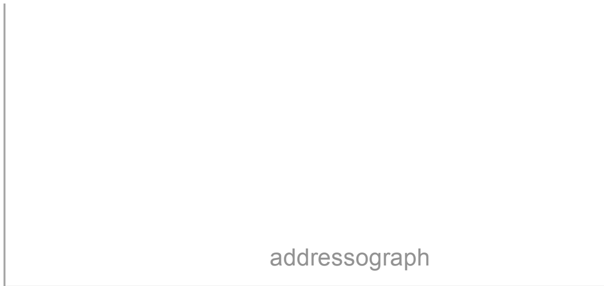
☐ Consultation
☐ Inpatient Assessment and Treatment
☐ Outpatient Treatment

Medication Assessment Program for Schizophrenia (MAPS):

Queen St. fax to 416-583-4601 **(Tel. No. 416-535-8501, ext. 3156)**
College St. fax to 416-979-4292 **(Tel. No. 416-535-8501, ext. 4864)**

☐ Consultation ☐ Weight Assessment

Client/Patient Name: ______________________________
Health Record #: ______________________________



Continuing Care Division:

Fax No. 416-583-1319 **(Tel. No. 416-535-8501, ext. 2069)**

- ☐ Consultation
- ☐ Time-limited admission for diagnostic clarification (up to 1 month)
- ☐ Time-limited admission (up to 3 months) to treat instability due to:
  - ☐ Poor response to biological, psychological and social interventions (i.e. medication, ECT)
    List of previous medications
    ____
    ____
- ☐ Intermediate outpatient treatment (up to one year) ~ please specify:
  ____
  ____
  ____
- ☐ On-going outpatient follow-up ~ please specify reasons:
  ____
  ____
  ____

DETAILS

Primary Diagnosis: ______________________________ Secondary Diagnosis: ______________________________
____

Current Medications and Doses: ______________________________
____
____

History of Alcohol/Substance Use: ______________________________
____

Legal History: ______________________________
____

Client/Patient Name: ______________________
Health Record #: ______________________

addressograph

Medical History: ______________________

____

Past Psychiatry History:

- Number of admissions in last 5 years ______________
- Longest period of time out of hospital in last 5 years ______________
- Longest hospitalization in last 5 years ______________
- Previous Diagnosis

____

____

____

NEXT OF KIN/FAMILY INFORMATION

Name: ______________________ Relationship: ______________________

Address: ______________________ Telephone (home): ______________

______________________ (work): ______________

Name and Relationship of Substitute Decision Maker (if applicable): ______________

______________________ Telephone: ______________

Please include the following documents:

(i) Typed Admission Notes/ Discharge Summaries
(ii) Computerized Visit History (if available)