CATCHMENT FOR SERVICES

- **East of Yonge St.**
- **West of Victoria Park Ave.**
- **North of Lake Ontario**
- **South of Bloor St.**

Ambulatory Mental Health and Addictions Service (MHAS) Referral

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

UNITY HEALTH TORONTO

REFERRING PHYSICIAN'S INFORMATION:		
Physician's Name:	OHIP Billing #:	
Address:		Postal Code:
Tel:	Fax:	Email:
Specialty (specify):	Family Physician (if different):	

PATIENT INFORMATION:			
Lives in catchment area (see above) ☐		Patient consents to referral ☐	
Reasons for non-catchment referral: _____		Requires Interpretation Services **Y** ☐ **N** ☐	
		Language:_____	
Last Name:	First name:		MRN(if available):
Address:			
Postal Code:	Tel:	Mobile:	Gender:
DOB (MM/DD/YY)	Health Card Number:		Version Code:
Consent to leave message: Voicemail **Y** ☐ **N** ☐		With another person: **Y** ☐ **N** ☐	

PLEASE CHECK BOXES TO INDICATE REFERRAL MEETS THE FOLLOWING CRITERIA:

- ☐ Patient informed services are time-limited
- ☐ Referral is not from a hospital that has psychiatric services (unless patient in SMH catchment)
- ☐ Patient does not have psychiatrist, or if patient does, referral is with the psychiatrist's knowledge
- ☐ Assessment is not being requested for a legal or compensation matter – e.g. court, CAS, WSIB, insurance, etc.
- ☐ Referring physician agrees to accept patient back once psychiatric care is complete
- ☐ If applicable, referral from SMH FHT reviewed by Collaborative Care psychiatrist (please include psychiatrist's note)

SELECT MENTAL HEALTH SERVICE REQUESTED (CHOOSE ONE ONLY):	
Mental Health Assessment Clinic (General Psychiatry):	
☐ Consultation only	☐ For consultation and short-term follow-up
Sub-specialty Mental Health Assessment:	
☐ Mood Disorders	Complex mood patients who have received previous psychiatric care
☐ Medical Psychiatry Attach extra page if required	Please identify medical condition(s): _____ If HIV please indicate CD4:_____ Viral Load:_____ SMH subspecialists providing ongoing care: _____
☐ Neuropsychiatry and Brain Injury	Please include relevant consultation/imaging reports
☐ Addiction Psychiatry	Referral for non-urgent addictions assessment *RAC drop-in for urgent cases
☐ Geriatric Psychiatry	Mental health assessment for patients ages 65+
☐ Memory Clinic	MoCA score:_____ MMSE:_____ Please include CT, MRI, SPECT reports
☐ Child Psychiatry	Mental health assessment for children ages 5 to 17

REASON FOR REFERRAL:

ADDITIONAL INFORMATION:

Past Psychiatric History (please include most recent consultation, discharge summary or notes):

Past Psychiatric Medication Trials:

Date Medication Dose Outcome

Past Medical History (please include relevant reports or attach patient profile summary):

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

Allergies:

RISK ISSUES	PRESENT		PAST		DETAILS
	Y	N	Y	N	
Forensic Charges					
Violent Behaviour					
Suicide Attempts					
Substance Use					
Other Self Harm Behaviour					

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

Signature: _____ Date of referral: _____

Name (print): _____ Designation: _____

PLEASE NOTE THAT FORMS THAT ARE INCOMPLETE OR NOT CLEARLY PRINTED WILL BE RETURNED