**Please read before completing/submitting the referral form**
**MEDICAL PSYCHIATRY (INCLUDING HIV and TRANSITIONAL AGED YOUTH) REFERRAL**
**Instructions and Information**
**FAX TO: 416-586-8654 INQUIRIES: 416-586-4800 ext. 8714**

**Medical Psychiatry Clinic:**
The Medical Psychiatry Clinic will see patients aged 18-64 followed by a Sinai Health GIM or Surgery provider who require psychiatric consultation.

- *Transitional Aged Youth stream:* Those aged 18 to 30 will be served by the Transitional Aged Youth stream.
- *HIV stream:* Accepts patient living with HIV (does not require a Sinai provider).
- ***Patients 65 and older will be triaged to Geriatric Psychiatry.***

**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: emphasis will be on psychiatric consultation to referring providers and time-limited 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. 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 may be inactivated. Patients are welcome to contact us directly at 416-586-4800 ext. 8714 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

**Incomplete forms will be returned to the referral source and the referral will be closed if adequate information is not provided.**

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

Department of Psychiatry Medical Psychiatry Outpatient Clinic Referral Form

CLEAR FORM PRINT FORM

# 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

Phone: _____ Patient consents to leave message: ☐ Yes ☐ No

Email: _____ Patient consents to email: ☐ Yes ☐ No

## 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

**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

**For Medical Psychiatry referrals: What diagnosis is the patient in treatment with the referring provider for?**

*Please attach relevant clinical and medical documentation*

Details:

Has the patient been diagnosed with HIV? ☐ Yes ☐ No
If yes, indicate year of HIV diagnosis: _____

## 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 | | | |
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