NORTH HALTON MENTAL HEALTH CLINIC
CLIENT REFERRAL FORM

Referrals should be sent to our Milton location at 217 Main St East. L9T 1N9.
Fax: 905-693-0596 - Phone: 905-693-4240

REFERRAL INFORMATION

Date of Referral: _____ **Referral Source:** _____
Referral Status: _____

GENERAL INFORMATION

Name:_____ DOB: _____ Age: _____
Address: _____ ❑ Acton ❑ Georgetown
_____ ❑ Milton ❑ Other: ____
Phone: (Home) _____ (Cell) _____
Health Card #_____ Allergies:_____
Parent contact information (where appropriate) Home/Cell):_____
Address (if different from person being referred):

Name of Family Physician: _____Phone number:_____
Address: _____ Fax:
Is the individual aware of this referral? Y N **Is the Parent aware of this referral? Y N**

CURRENT SITUATION

Presenting Issues/Problem

Reason client is seeking psychiatric services at this time

Other Agencies Involved

Brief Psych./Medical History (Medication Prescribed)

Recent Hospitalisations

Hospital: _____ Reason for admission: _____
Length of stay: _____ Non-admit, referred to: _____

Client Name:

MENTAL STATUS

❑ Alert	❑ Distressed	❑ Low energy
❑ Alcohol abuse	❑ Drug abuse	❑ Oriented (time/place/person)
❑ Angry	❑ Hallucinating	❑ Paranoid
❑ Anxious	❑ Helpless	❑ Poor concentration
❑ Appetite loss	❑ Hopeless	❑ Memory changes
❑ Bizarre	❑ Indifferent	❑ Poor insight
❑ Calm	❑ Insomnia	❑ Tearful
❑ Decreased motivation	❑ Anxiety	❑ Weight gain
❑ Delusional	❑ Labile mood	❑ Weight loss
❑ Depressed	❑ Sleep problems/changes	

RISK ASSESSMENT

Symptom	Yes	No	Notes
Suicidal thoughts	❑	❑	
Plan	❑	❑	
Previous attempts	❑	❑	
Danger to self	❑	❑	
Homicidal thoughts	❑	❑	
Violent intentions	❑	❑	
Fears consequences	❑	❑	
Command hallucinations	❑	❑	
Danger to others	❑	❑	
Poor impulse control	❑	❑	
Poor social supports	❑	❑	
Willing to accept help	❑	❑	

Danger Potential

Danger to Self: ❑ Low ❑ Moderate ❑ High
Danger to Others: ❑ Low ❑ Moderate ❑ High

*** **PLEASE FORWARD RECENT BLOODWORK, PREVIOUS CONSULTATIONS AND ANY RECENT INVESTIGATIONS (I.E., CT SCAN, EEG, EKG).**

*** Physician Signature:** *** Billing Number:**

OUTCOME (To be filled out by Clinic Staff)

Referral appropriate: ❑ Yes ❑ No
Referred to psychiatrist for meds: ❑ Yes ❑ No
Referred to appropriate agency: ❑ Yes ❑ No