



Mental Health Ambulatory Services Referral Form
Phone: 705-728-9090 Psychiatry: x47210 MHA Day Program X47260
Fax: 705-739-5631

The Mental Health Ambulatory Services accepts referrals where there is a primary psychiatric concern. We provide short term consultation and stabilization for patients age 16 and above.

Referral forms that are incomplete will not be processed and will be returned. The Mental Health Ambulatory Services accepts referrals for patients living within the primary catchment of the Greater Barrie area.

Client/Patient Information	
Date patient was last seen: _____ (yyyy/mm/dd)	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Is patient agreeable to referral? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please do not proceed with referral	
_____ Patient Name	_____ Date of Birth (yyyy/mm/dd)
_____ Address	
_____ Health card number	
_____ Provide a working phone number	Can leave message? <input type="checkbox"/> Yes <input type="checkbox"/> No
Marital status	<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated
(this information is used by the hospital to register patients)	<input type="checkbox"/> Married <input type="checkbox"/> Widowed

All referrals will be screened for appropriateness.

We are NOT able to accept referrals for assessments/treatment where concerns are related primarily to:

- | | | |
|---------------------------|---------------------|--------------------------|
| Anger management | Chronic pain | Relationship counselling |
| Autism spectrum disorders | Developmental delay | |

We do not provide assessments for legal, insurance, custody, Children’s Aid Society (CAS), Workplace Safety and Insurance Board (WSIB) or forensic reasons

Is the patient involved in current/pending legal, compensation or insurance claims? Yes No

If yes, please explain: _____

Service Request:	
Psychiatric Consult (select one): <input type="checkbox"/> Medication review <input type="checkbox"/> Diagnostic clarification <input type="checkbox"/> Short-term management <input type="checkbox"/> Ontario Telemedicine Network (OTN) if available	Mental Health & Addiction Day Program (select one): <input type="checkbox"/> Mental Health & Addiction Day Program <input type="checkbox"/> Brief transitional case management

Reason for referral: _____



