WOODSTOCK HOSPITAL
Woodstock, ON
MENTAL HEALTH

OUTPATIENT MENTAL HEALTH SPECIALIZED SERVICES INFORMATION AND REFERRAL FORM

Telephone: 519–421–4223 Extension 2232 Fax: 519–421–4247

PRIVATE AND CONFIDENTIAL

CRITERIA FOR OUTPATIENT SPECIALIZED MENTAL HEALTH SERVICES

PSYCHIATRY

- Referring Physician/Primary Care Provider has tried previous interventions that have not been successful at stabilizing the person
- Referring Physician/Primary Care Provider is willing to provide medical care and ongoing follow –up to the patient

PEPP-OXFORD PROGRAM (Prevention & Early Intervention Program for Psychoses)

- Individual must be between 14 and 35 years of age
- Individual is experiencing symptoms of psychosis or early psychosis unrelated to methamphetamine use in the last 3 months
- Individual has received either no previous treatment, or 6 months or less of treatment for psychosis

BSO (Behavioural Supports Ontario) GERIATRIC OUTREACH TEAM

- Individual must be 65 years of age or older
- Individual is experiencing, or is at risk of, developing Responsive Behaviours as a result of dementia, mental health, or addictions

EATING DISORDER PROGRAM

- Individual's primary presenting problem is an Eating Disorder and there is a preliminary or confirmed diagnosis of an Eating Disorder
- Individual must be medically stable, have a family physician, and 12 years of age or older
- If BMI is under 16.5, the individual must be referred elsewhere for more intensive treatment
- If BMI is between 16.5 and 18.5, the individual may need to be referred to London Health Sciences Centre (LHSC) unless the individual is medically stable

INFORMATION FOR REFERRAL SOURCE

- A referral from a physician or nurse practitioner is required for Psychiatry and Eating Disorders Programs
- Endorsement from a physician may be required for all other Outpatient Specialized Mental Health Services at Woodstock Hospital
- Information that is marked '***REQUIRED***' on the referral form must be completed in full
- Information requested in the referral form may be sent as an attachment with the referral if sufficient space is not provided
- Please note, referrals will not be accepted for Mental Health Outpatient Counselling Services. Please see 'Information for Individuals Being Referred' for additional information on how individuals can access counselling services
- The referring provider must inform whether subsequent referrals were made to similar programs to avoid duplication

****If a referral needs to be cancelled for any reason, please contact our office to inform us of the change in status ****

INFORMATION FOR INDIVIDUALS BEING REFERRED

- The referred individual must be aware that an Specialized Mental Health Services Form is being completed. If not, please provide explanation on referral
- Appointment booking will be communicated through telephone to the patient/caregiver and via fax to the referral source
- If an individual´s contact information changes, it is both the individual and the referring provider´s responsibility to update the contact information provided
- Woodstock Hospital Staff will make two attempts to contact the individual, by voicemail and/or letter, when consent is provided. If the individual cannot be reached, referral source will be notified
- Individuals can call Outpatient Mental Health Services to receive an update on the status of their referral
- Individuals that also require Mental Health Counselling Services can attend **Oxford County Talk–In Counselling**
- To receive ongoing Mental Health Counselling through Woodstock Hospital, it is recommended that individuals first access alternative supports through EAP, Primary Care Provider´s Counselling Services, and/or private psychotherapy if benefits are available

HOW TO SUBMIT A SPECIALIZED REFERRAL

- Please fax all Outpatient Mental Health Specialized Referrals to: **519–421–4247**
- Please ensure each referral is faxed individually
- To help us provide the best care possible, please complete **BOTH** pages of the referral form and include **all relevant documents**, such as previous psychiatric consultations, discharge summaries, medication administration records, psychological/mental health notes, lab and test results, and medical information.

**** Please note that referrals that do not have sufficient information and/or are incomplete will be sent back to the referral source requesting additional information. If we are unable to obtain additional information, this may result in the referral being closed. We welcome another referral to be sent once sufficient information is obtained ****

If an individual requires immediate response, please refer patient to REACH OUT:1–866–933–2023, the nearest Emergency Department or call 911

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REASON FOR REFERRAL AND CRITERIA CHECKLIST - *REQUIRED* (Please check all that apply)

☐ **PSYCHIATRY**

- ☐ Individual is a resident of Oxford County or affiliated with an Oxford County Physician
- ☐ Primary Care Provider has tried previous interventions that have not been successful at stabilizing the person
- ☐ Reason for Referral (e.g. diagnostic clarification, medication review , treatment recommendations, etc.):

_____

☐ **PEPP–OXFORD PROGRAM (Prevention and Early Intervention Program for Psychoses)**

- ☐ Individual is 14 to 35 years of age, residing in Oxford County or affiliated with an Oxford County Physician
- ☐ Individual is experiencing symptoms of psychosis or early psychosis, unrelated to crystal meth use in the last 3 months
- ☐ Individual has received either no previous treatment, or 6 months or less of treatment for psychosis

☐ **BSO (Behavioural Supports Ontario) GERIATRIC OUTREACH TEAM**

- ☐ Individual is 65 years of age or older, residing in Oxford County or affiliated with an Oxford County Physician
- ☐ Individual is experiencing, or is at risk of, developing Responsive Behaviours as a result of dementia, mental health, or addictions

☐ **EATING DISORDER PROGRAM**

- ☐ Individual is 12 years of age or older, resides in Oxford County, and has a Family Physician
- ☐ Primary presenting problem is an Eating Disorder; there is a preliminary or confirmed diagnosis of an Eating Disorder
- ☐ Individual´s BMI is greater than 16.5 and individual is medically stable (please provide height, weight, and BMI)

PATIENT INFORMATION - *REQUIRED* (Please provide the most current information)

Is patient aware/supportive of this referral? ☐ Yes ☐ No (if no, please explain) _____

Legal Name: _____ DOB (mmm,dd,yyyy): _____ Age: _____

Preferred Name (if different from above): _____ Gender: _____ Sex: _____

Health Card Number: _____ VC: _____ Family Physician: _____

Address: _____ _____ _____ _____

Street | Town/City and Province | Postal Code | Unit Number

Telephone: (1) _____ (2) _____ Consent to Voicemail: ☐Yes ☐No

Email: _____ Consent to Email ☐Yes ☐No

Living Arrangements (ie self, spouse, parents, long–term care, group home, etc): _____

Custody Status (for youth under the age of 16): _____

Special Considerations (ie interpreter, accessibility needs, etc): _____

DELEGATE CONTACT INFORMATION / CARE PROVIDER (if applicable)

By providing this information, the referral source confirms that the individual being referred consents for Woodstock Hospital to call/email the delegate on their behalf. Woodstock Hospital will refrain from communicating personal health information until consents are verified

Name of Delegate Contact: _____ Relationship to Individual: _____

Telephone: (1) _____ (2) _____ Consent to Voicemail: ☐Yes ☐No

Email: _____ Consent to Email ☐Yes ☐No

RISK ISSUES (if applicable)

☐ **Recent Suicide Attempt** ☐ **Active self–harm behaviour** ☐ **Violence or aggression** ☐ **Legal involvement**

If any of the above risk factors are of concern, we REQUIRE additional details

Please see reverse

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REFERRAL SOURCE INFORMATION - *REQUIRED*

We REQUIRE the referring physician or the individual's MRP to continue to be available for ongoing medical care

I will continue to provide medical care and ongoing follow–up to this patient ☐ Yes ☐ No

☐ Family Physician
☐ ED or Walk–In Clinic Physician
☐ Hospital
☐ Psychiatrist
☐ Other: _____

Name		
Billing Number (if applicable)		
Organization		
Address		
Phone and Fax Number	P:	F:
Email		

PRESENTING CONCERNS - *REQUIRED* (please attach if details are expansive of the space provided)

Please provide a brief narrative explaining presenting concerns and symptoms, including duration and frequency of symptoms, psychosocial factors, substance use and **all** other current and historical information that is relevant

MENTAL HEALTH SERVICES INVOLVED IN THE PAST 5 YEARS – *REQUIRED* (attach notes if applicable)

Organization	Current	Describe Involvement
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	

MEDICAL/PHYSICAL HEALTH– *REQUIRED*

Please provide a list and details of any relevant medical/physical health considerations (ie specific illnesses,chronic pain, difficulty coping with medical illness, etc)

Potential organic causes for symptoms have been ruled out (ie thyroid issues, medication, head injury, etc)

MEDICATIONS – *REQUIRED* ☐ attached

Please include both psychiatric and non–psychiatric medication, including all current and previously trialed medications. Please attach medication list if medications are expansive of the space provided

Medication	Current	Dose	Frequency	Responsive/Adverse Effects
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			

SUPPLEMENTAL INFORMATION (please attach if possible)

****This information is highly valued and my be required****

Medical/Psychological/Psychiatric history ☐ **attached**
Hospital Discharge Summaries ☐ **attached**
Psychiatric Hospitalization(s) ☐ **attached**
Recent laboratory results (ie blood work, urinalysis) ☐ **attached**
Other Assessments (ie MMSE, DOS, GAIN–SS, PHQ–9, GAD–7)) ☐ **attached**
MoCA ***REQUIRED FOR ALL PATIENTS OVER THE AGE OF 65** ☐ **attached**