Canadian Mental Health Association
Durham
Mental health for all

Association canadienne pour la santé mentale
Durham
La santé mentale pour tous

Nurse Practitioner Led Clinic
60 Bond Street West, 2nd Floor
Oshawa, Ontario
Tel: (905) 436-9945

Referral to the Nurse Practitioner Led Clinic

PATIENT INFORMATION

_________________ *First Name* _________________ *Last Name* _________________ *Preferred Name*

_________________ *Sex* _________________ *Gender* _________________ *Language Spoken*

_________________ *Health Card Number & Version Code* _________________ *Allergies* _________________ *Diagnosis*

____
Phone Number (check for permission to leave message) ☐

Date of Birth: ______/______/______ DD MM YYYY

____
Email Address (check for permission to communicate via email) ☐

____
Address *City* *Postal Code*

No Fixed Address: ☐

REASON FOR REFERRAL

☐ **Needs a Primary Care Provider**

Specify Past Primary Care Provider: _________________

Last Appointment with Above Provider: _________________

☐ **CANDID Program**

Specify Palliative or Life-Limiting illness: _________________

☐ **Clozapine Monitoring**

You must provide:

1. CSAN # with ordered frequency of lab work
2. A Baseline ECG
3. Recent Medication List
4. Discharge Summary

☐ **Depot Injection Services**

You must provide:

1. A Prescription for Depot Injection
2. Date of Last Dose
3. Recent Medication List
4. Discharge Summary

☐ **Trans Health Care Services**

☐ **Psychiatrist Consult**

You must provide:

Email Address: _________________
Primary Care Provider & Number: _________________
Verbal Consent for CMHA to contact Primary Care Provider: ☐

Please fax this form to Community Connection Services at 905-436-1569

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CIRCLE OF CARE

Current Doctor/Primary Care Provider:___________________________

Psychiatrist:___________________________

Other Practitioners:___________________________

Current Pharmacy: ___________________________

RISK ASSESSMENT

☐ Hx Violence Towards Others ☐ Sexual Aggression ☐ Hx Concealing Weapons
☐ Hx Violence Towards Self ☐ Hx Suicide Attempt ☐ Hx Fire-Setting
☐ Hx Violence Towards Property ☐ Other:___________________________
☐ Falls *(if yes, please describe functional mobility/assistive devices)*:

____

☐ None

LEGAL INFORMATION *(if no legal involvement, leave this section blank)*

☐ Criminal record ☐ NCR
☐ Current charges *(if yes, please describe)*: ☐ Past charges *(if yes, please describe)*:

___________________________ ___________________________

☐ None

REFERRAL SOURCE

☐ ***I am referring myself*** ☐ ***I am referring someone else with their consent.***

Your Name: ___________________________

Your Phone Number: (_____)______________________Fax Number (if applicable): ____________________

Relationship to the person being referred:_________________Date of Referral:_________________________

We will confirm processing of this referral provided that you have included ALL requested information.

Please fax this form to Community Connection Services at 905-436-1569