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/Chosen Name*	*Date of Birth (DD/MM/YYYY)*
Sex	*Gender*	*Pronouns*	*Language Spoken*

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

______ *Phone Number*
(Check for permission to leave messages) ☐

______ *Email Address*
(Check for permission to communicate via email) ☐

______ *Address*
(Check for No Fixed Address) ☐

______ *City*

______ *Postal Code*

REASON FOR REFERRAL

Primary Care Services ☐ ***Fields marked with an asterisk (*) are required*** **Trans Health Care Services** ☐ ***Fields marked with an asterisk (*) are required***	☐ Past Primary Care Provider: ______ ☐ Last Appointment with Above Provider: ______ ☐ *Recent Medication List from client's pharmacy ☐ *Consent to request records attached/sent
CANDID Program ☐ ***Fields marked with an asterisk (*) are required***	☐ *Specify Palliative/Life-Limiting Illness: ______
Clozapine Monitoring ☐ ***Fields marked with an asterisk (*) are required***	☐ *CSAN# with frequency of lab work ☐ *Baseline ECG ☐ *Recent Medication List from client's pharmacy ☐ Discharge Summary (if applicable)
Depot Injection Services ☐ ***Fields marked with an asterisk (*) are required***	☐ *Prescription for Depot Injection ☐ *Date of Last Dose ☐ *Recent Medication List from client's pharmacy ☐ Discharge Summary (if applicable)
Psychiatrist Consult ☐ ***Fields marked with an asterisk (*) are required*** *1-time consult only. **Must** have a primary care provider.48h required to cancel/rebook, no-shows cannot be rebooked.*	☐ *Email Address: ______ ☐ *Primary Care Provider & Number: ______ ☐ *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/Specialists: ______________________________

Current Pharmacy: ______________________________

RISK ASSESSMENT

☐ Hx Violence Towards Others
☐ Hx Violence Towards Self
☐ Hx Violence Towards Property
☐ Hx Suicide Attempt
☐ Hx Concealing Weapons
☐ Hx Fire-Setting
☐ Hx Sexual Aggression
☐ Falls (describe functional mobility/assistive devices if so)
☐ Other
☐ None

If yes to any of the above, please describe: ______________________________

____

LEGAL INFORMATION

☐ Criminal Record
☐ Current Charges (if yes, please describe)
☐ None
☐ NCR
☐ Past Charges (if yes, please describe

Description of charges: ______________________________

____

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 ALL requested information is included

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