camh
Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

CAMH REFERRAL FORM

D0359A

Client/Patient ID Label

(For CAMH use only)

Date of referral (dd/mm/yyyy): _____

CLIENT/PATIENT INFORMATION

Legal name: Doe, John

(last name, first name)

Preferred name (if applicable): Doe, John

Mother's maiden name: ***

Date of birth: 23/07/1990

(dd/mm/yyyy)

For persons 16 years and older, consent is required for assessment to be completed. Please ensure you have spoken to the person about the referral.

Is your client/patient aware of this referral? Either 'Yes' or

☐ Yes ☐ No If no, please explain: 'Incapable of consent'

What is your client's/patient's gender? Check ONE only:

☐ Female ☐ Male
☐ Trans - Female to Male ☐ Trans - Male to Female
☐ Intersex ☐ Other (please specify)
☐ Prefer not to answer Please check one.
☐ Do not know

Telephone number(s) (specify home, office, cell, etc.)

Tel: 000-000-0000

Tel: 111-111-1111

If you are able to advise, please confirm if confidential messages can be left at the numbers provided above:

☐ Yes ☐ No Details: Please ask client while they're in your office.

By listing an e-mail, the referral source confirms that the client consents for CAMH to e-mail appointment details and is aware that e-mail is not entirely secure. CAMH will refrain from sending unrequired personal information until e-mail addreses and consents are verified.

E-mail address: ***

Address: Street #, Street Name
City, Province, Postal Code

Health card #: 012 345 6789

Version code: AA Expiry date: 03/10/2020

(dd/mm/yyyy)

Is there a need for an interpreter (e.g., for sign language or other language)?

☐ Yes ☐ No If **Yes,** please specify: Please check one.

REFERRAL SOURCE INFORMATION

Name: Doctor or NP ONLY

(last name, first name)

Check one: ☐ Family Physician ☐ Nurse Practitioner ☐ Psychiatrist
☐ Other: _____

Tel: 222-222-2222

Fax: 333-333-3333

E-mail address: ***

Address: Street #, Street Name
City, Province, Postal Code

Billing number (if referred by physician): 123456

Is client's/patient's current psychiatrist aware of referral?

☐ Yes ☐ No ☐ Unknown ☐ Does not have psychiatrist

If **Yes**, name of psychiatrist:

Current psychiatrist MUST be made aware.

(last name, first name)

*** CLIENT/PATIENT ETHNICITY INFORMATION

Which of the following best describes client/patient racial or ethnic group?

Check ONE only.

☐ Asian - East (e.g., Chinese, Japanese, Korean)
☐ Asian - South (e.g., Indian, Pakistani, Sri Lankan)
☐ Asian - South East (e.g., Malaysian, Filipino, Vietnamese)
☐ Black - African (e.g., Ghanaian, Kenyan, Somali)
☐ Black - North American (e.g., Canadian, American)
☐ Black - Caribbean (e.g., Barbadian, Jamaican
☐ First Nations - Non-status
☐ First Nations - Status
☐ Indian - Caribbean (e.g., Guyanese with origins in India)
☐ Indigenous / Aboriginal not included elsewhere
☐ Inuit
☐ Latin American (e.g., Argentinean, Chilean, Salvadorian)
☐ Métis
☐ Middle Eastern (e.g., Egyptian, Iranian, Lebanese)
☐ White - European (e.g., English, Italian, Portuguese, Russian)
☐ White - North American (e.g., Canadian, American)
☐ Mixed heritage (e.g., Black-African and White-North American) *(Please specify)*
☐ Other(s) *(Please specify)*
☐ Prefer not to answer
☐ Do not know

*** ALTERNATE CONTACT INFORMATION (CLIENT/PATIENT OR LEGAL GUARDIAN CONSENT MAY BE REQUIRED)

Is there anyone other than the client/patient that we should contact? ☐ Yes ☐ No _____ Relationship to client/patient: _____

(last name, first name) Tel: _____ Tel: _____

*** GUARDIAN AND CUSTODY STATUS (IF APPLICABLE)

Custody Status: ☐ Lives with both parents ☐ Joint Custody (both parents need to be aware and consenting to the assessment) ☐ Sole custody ☐ Client lives independently ☐ Other (CAS/relative) _____

1. Guardian name: _____
   Telephone #: _____
2. Guardian name: _____
   Telephone #: _____

Clear Form

All fields are required. Fields with *** are not mandatory, but should be completed if applicable.

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Every part of this page MUST be fully completed, with as much details as possible. Please include a letter if there isn't enough space.

Client/Patient ID Label

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Client/patient name: Doe, John

1. REASON FOR REFERRAL (e.g., consultation, goals for assessment, treatment)
Why are you referring the patient now? (e.g., current symptoms, presenting problems, history)

Please provide as much information as possible regarding: presenting problem(s), symptoms, previous treatment, history, and the goals for assessment.

1. SUBSTANCE USE (current substances, amount, frequency of use, etc.): Does client/patient want help with this issue? ☐ Yes ☐ No

3. RISK ISSUES

RISK ISSUE	CHECK	IF YES, WHEN?	DETAILS
Suicide attempt / ideation	☐ Yes ☐ No		
Deliberate self-harm	☐ Yes ☐ No		
Violent behaviour	☐ Yes ☐ No		
Legal involvement	☐ Yes ☐ No		
Fire Setting	☐ Yes ☐ No		

4. MEDICATIONS (psychiatric and non-psychiatric - attach additional information if needed)

MEDICATION	CURRENT	PAST	DOSE / FREQUENCY	RESPONSE & ADVERSE EFFECTS

5. AGENCIES, HOSPITALS OR THERAPIES INVOLVED WITHIN THE PAST TWO YEARS

Please try to avoid acronyms, and fax any records along with this referral.

6. RELEVANT MEDICAL / DEVELOPMENTAL HISTORY (e.g., disabilities, intellectual delay, autism, allergies, endocrine, neurological, respiratory, cardiac, metabolic or other issues)

Completed by: _____ (print name and credentials)

When completing electronically, the form should be printed, signed and faxed to CAMH. _____ (signature)

Date: _____ (dd/mm/yy)

Clear Form