Canadian Mental Health Association
York and South Simcoe
Mental health for all

Rapid Access Psychiatry Mood & Anxiety Program - Referral Form
FAX: 905-841-3007 TEL: 1-877-345-0183 x6560

Patient Name: ______________________________________ Date of Birth: ____________ (MM/DD/YYYY)

Address: ____ (*MOA: Please apply patient*
____ **label or print legibly)**

Telephone: ____ Messages OK? Yes: ☐ No: ☐

Email: ____

Referring Physician's Name: ____________________________________ Billing #: __________________

Address: ____

Telephone: ____ Fax: _______________________________

Due to the specialized services offered through the Rapid Access Mood & Anxiety Psychiatry Program, please confirm that the client being referred:

- ☐ Is not at risk to harm self or others
- ☐ Is not significantly misusing alcohol or drugs
- ☐ Does not have a personality disorder
- ☐ Has not had episodes of mania or psychosis within the past 1 year
- ☐ Is capable of completing online questionnaires and engaging with our program, if eligible.

Reason for consultation: (check all that apply)

- ☐ Low mood
- ☐ Anxiety
- ☐ Stress

Psychiatric History:

Current psychiatric diagnosis and treatment ____

History of psychiatric diagnosis and treatment ____

Outpatient (date/reason) ____

Inpatient (date/reason) ____

Therapy types and therapists ____

Groups/programs ____

History of ☐ Aggression ☐ Agitation ☐ Impulsivity ☐ Irritability ☐ Homocidality

Please describe ____

History of suicidality and/or self harming behaviours ☐ Yes ☐ No

Please describe ____

Medical & Surgical History:

Please list medical & surgical treatment and diagnosis

____

Family History:

Medical conditions ____

Psychiatric conditions ____

Substance misuse ____

Suicide ____

Medications:

Current medications, including dosage, frequency, when started and duration (please list)

____

Past trials including side effects, efficacy, tolerability, dosing titration, adverse events, and reason for discontinuation (please list)

____

Use of Over the Counter (OTC) products, supplements, herbal, or natural remedies (please list)

____

Allergies ____

Substance Use: (include amount, frequency, duration, etc)

☐ None

☐ Cigarettes/tobacco ____

☐ Alcohol ____

☐ Non-prescription drugs ____

Additional Information:

____