Huron Health System
SYSTEM
Alexandra Marine & General Hospital

Huron Health System
PSYCHIATRIST Referral Form

Please note, our service is unable to provide support in an emergency. If your client is experiencing a mental health crisis and requires immediate help, advise them to contact the Huron Perth Helpline and Crisis Response Team at 1-888-829-7484 or go to the nearest emergency department.

All sections of this form must be complete in order to proceed with the referral**.**

ALL OF THE FOLLOWING CRITERIA MUST BE MET PRIOR TO THE REFERRAL BEING ACCEPTED:

- Must be a current resident of HURON COUNTY or be a rostered patient from a FHT in Huron County
- Must be older than 16 years of age
- Primary Care Provider must be willing to provide ongoing follow up

We will provide Consultation and is some cases follow up based on clinical situation.

Dr. Doering only sees clients over 65 years old and under 65 if they have a dementia. Otherwise, we do *NOT* accept referrals to specific psychiatrists but please indicate if one of our psychiatrist has seen the client previously.

We do ***NOT*** accept referrals for psychotherapy – if provider is looking for psychotherapy please contact Huron Community Mental Health Services at 1-877-695-2524 (for CBT, DBT, Disordered eating etc.)

If substances are the primary issues please contact CMHA Huron Perth Addiction & Mental Health Services at 1-888-261-9350

I will continue to provide medical care and ongoing follow up ☐ **Yes** ☐ **No**	
Is patient aware of the referral, if no please explain: ☐ **Yes** ☐ **No**	
Date:	**Health Card#** **Version**:
Full Legal Name (on health card): **Preferred name:**	**Gender**: ☐ M ☐ F ☐ Other Preferred pronouns: _____/_____ **Marital Status**:
Mailing Address:	**911 Address**: **Email address**:
Postal Code:	**Birth date**: / / DD / MM / YYYY **Age**:
Telephone Numbers (Primary): **Messages can be left?** ☐ Yes ☐ No	(Secondary): Messages can be left? ☐ Yes ☐ No
Delegate Contact Info:	**Relationship**:
Telephone Number: **Messages can be left?** ☐ Yes ☐ No	**Telephone Number**:

Current safety factors: Assess and check all that apply below and provide details.

☐ Recent Suicide Attempt ☐ Active Self-Harm Behaviour ☐ Violence or aggression

☐ Current Substance use ☐ Legal Involvement ☐ Psychotic Symptoms

Other:

Details:

Reason for Referral:

Past / Current Involvement with Mental Health Services:

Past Medical History (including relevant investigations):

Medication List & Past Medication Trials:

Supplemental documents, i.e. Psychiatric / Psychological Assessments, Discharge Summaries etc. Attached ☐ Yes ☐ No

REFERRAL SOURCE:

Name: **Phone #:** **Fax #:**

Address: **City:** **Postal Code:**

☐ Family Physician ☐ Nurse Practitioner ☐ ED Physician/Nurse Practitioner ☐ Walk-In Clinic Physician

☐ Specialist: _____ ☐ OHIP Billing #: _____

Signature: _____

Fax COMPLETED Referral Form to 519-524-8513