# Referral Form
# Instructions and Information

## Information for Referring Providers

**Catchment Area:**

- one-Link is the coordinated access service for referrals for Mississauga Halton LHIN funded Addictions and Mental Health Service Providers. For services outside of this area, please contact Connex Ontario for the most appropriate resources. www.connexontario.ca

**Referral Process:**

- Once you have submitted a referral, it is reviewed by one-Link and either forwarded directly to the appropriate service, or a telephone screening is scheduled with the client to gather more information and determine the next step. We will leave two voice mail messages and the number will appear as Halton Healthcare. Clients are welcome to contact us directly at **905-338-4123** or Toll free at **1-844-216-7411** to discuss their referral at any time.

| Urgent (processed by one-Link within 1-5 days) | Non-Urgent |
|---|---|
| • Antepartum / Postpartum<br>• Psychosis<br>• Withdrawal Management<br>• Eating Disorders | • Psychiatric Consultation<br>• Other Mental Health Treatment & Recovery Support<br>• Grief, Trauma, Marital, or other Counselling<br>• Addictions Treatment & Recovery Support<br>• Employment Supports<br>• Supportive Housing |

## Access to Adult Services – Age 17.5 and older

**Psychiatric Consultation:**

- **Inclusion Criteria:** One-time psychiatric consultation is available with the understanding that the referring physician is responsible for the implementation of recommendations. For conditions related to depressive and anxiety disorders, there must be evidence of two medication trials within the current episode of illness.
- **Exclusion criteria:** Clients seeking long-term psychiatric follow-up, psychiatric consultation for court, custody, or insurance purposes, or a second opinion not being requested by the current treating psychiatrist.

**Access to Specialized Adult Services:**

one-Link does not have access to specialized services for the assessment or treatment of adult attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD), or developmental disability.

- The Canadian ADHD Resource Alliance www.caddra.ca provides assessment tool kits, practice guidelines, and patient resources.
- Developmental Services Ontario www.dsontario.ca
- CAMH Adult Neurodevelopmental Services www.camh.net

## Access to Child & Adolescent Services – Age 17.5 and under

**Psychiatric Consultation:**

- Referrals must clearly describe the concern and state if diagnostic clarification or medication recommendations are being requested.

## Crisis Services

one-Link has access to refer to **non-urgent services**. For clients experiencing a mental health or addiction emergency, consider issuing a Form 1 or direct them to their nearest hospital emergency department. The following services are also available for clients to contact 24 hours a day, 7 days a week:

| Halton | Peel / Etobicoke |
|---|---|
| • Halton Crisis Outreach and Support Team (COAST): 1-877-825-9011<br>• Reach Out Centre for Kids (up to age 17): 905-878-9785 | • 24.7 Crisis Support Peel: 905-278-9036<br>• 24.7 Crisis Support Pee (17yrs and under): 416-410-8615<br>• Gerstein Crisis Centre (south Etobicoke): 416-929-5200 |

# Referral Form: Fax to 905-338-2878

**Inquiries:** Toll Free: 1-844-216-7411 **Website:** www.one-Link.ca

one-Link
Connecting you to addictions and mental health services

Halton Healthcare
GEORGETOWN · MILTON · OAKVILLE

| **SECTION A: REFERRAL SOURCE INFORMATION** | ☐ **I am referring myself for services** |
|---|---|
| Name: | ☐ MD ☐NP ☐ Other:_____ |
| Billing #: | Address: |
| Signature: | Phone: |
| Referral Date: | Fax: |
| Family Physician Name: | Phone: |
| Does your client currently have a psychiatrist? ☐ No ☐ Yes – *if yes, please provide name, and attach consult note* | |
| Name: | |

| **SECTION B: CLIENT INFORMATION** | | |
|---|---|---|
| Last Name: | First Name: | Preferred Name: |
| OHIP #: | Version Code: | Date of Birth: (DD/MM/YYYY) |
| Gender: | Pronoun: | |
| Address: | | |
| City: | Prov. | Postal Code: |

Where is the client sleeping most frequently: ☐ Permanent Housing ☐ Outdoors ☐ Shelter ☐ Friends/Family

**CONTACT INFORMATION**

*The referral source confirms that the client consents for one-Link to call/email them or their alternate contact regarding this referral & appointment booking.*

Phone:_____ Email:_____

**ALTERNATE CONTACT**

Name: Phone: Relationship:

Preferred language: Is an interpreter requested? ☐No ☐Yes

**Considerations:** ☐Cognitive Impairment ☐Hearing Impairment ☐Sight Impairment ☐Age 65+ Housebound

**SECTION C: CUSTODY STATUS (for youth under the age of 16)**

☐ Joint Custody (Please fill out contact information for both guardians)

☐ Sole Custody (Please fill out contact information for the sole guardian)

☐ Live with both parents/Married/Common Law (Please fill out contact information for both guardians)

☐ Other (e.g. CAS), please specify:_____

1. Guardian Name:_____
   Phone:_____

2. Guardian Name:_____
   Phone:_____

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**Client Name:** _____ **Date of Birth** (DD/MM/YYYY):_____

## SECTION D: REASON FOR REFERRAL

**Why are you referring this client now?**

## SECTION E: RISK & SAFETY

☐ Violence / Risk to others ☐ Self-Harm ☐ Active Suicidal Thoughts ☐ Recent Suicide attempt

Details:_____

***(ONE-LINK REFERS TO NON-URGENT SERVICES ONLY. FOR CLIENTS EXPERIENCING A MENTAL HEALTH OR ADDICTION CRISIS DIRECT THEM TO CRISIS RESOURCES OR THE NEAREST HOSPITAL EMERGENCY DEPARTMENT)***

## SECTION F: CURRENT & PAST HISTORY

| Please check all that apply | Current | Past History | Details |
|---|---|---|---|
| Agitation | ☐ | ☐ | |
| Anxiety | ☐ | ☐ | |
| Bipolar Disorder | ☐ | ☐ | |
| Cognitive Decline / Confusion | ☐ | ☐ | |
| Depression | ☐ | ☐ | |
| Obsessive Compulsive Behaviour | ☐ | ☐ | |
| Eating Disorder | ☐ | ☐ | *Please complete **SECTION J** of the referral form* |
| Post-traumatic Stress Disorder | ☐ | ☐ | |
| Psychosis | | | |
| • Hallucinations | ☐ | ☐ | |
| • Confused Thinking | ☐ | ☐ | |
| • Delusions | ☐ | ☐ | |
| • Disorganized Speech | ☐ | ☐ | |
| • Paranoia | ☐ | ☐ | |
| Substance Use Concerns | ☐ | ☐ | |
| Substance Withdrawal Symptoms | ☐ | ☐ | |

## SECTION G: SERVICES REQUESTED - PLEASE CHECK ALL THAT APPLY

| | |
|---|---|
| ☐ Psychiatric Consultation | ☐ Addictions Treatment & Recovery Support |
| ☐ Mental Health Treatment & Recovery Support | ☐ Employment Supports |
| ☐ Early Psychosis Intervention | ☐ Supportive Housing |
| ☐ Grief, Trauma, Marital or other counselling | ☐ Other: |

## SECTION H: MEDICAL HISTORY *attach relevant clinical and medical history*

☐ Client is pregnant or has given birth within the past 12 months

*(A completed Edinburgh Postnatal Depression Scale (EPDS) by a physician MUST be attached for these referrals to be processed)*

☐ Falls / Wandering

## SECTION I: MEDICATIONS

Is the client currently on antipsychotic treatment for psychosis? ☐ No ☐ Yes

If Yes, Name(s), Dose & Frequency:_____

Total duration of all antipsychotic medication trials: ☐ 6 months or more ☐ less than 6 months

**Current / Historical Psychoactive Medication Trials -** *list or attach: (dose/frequency/name)*

| Medication Name | Current | Dose | Frequency | Response & Adverse Effects |
|---|---|---|---|---|
| | ☐ Yes ☐ No | | | |
| | ☐ Yes ☐ No | | | |

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**Client Name:** _____ **Date of Birth** (DD/MM/YYYY):_____

**SECTION J: EATING DISORDER – Only Complete If You Are Referring for Eating Disorders Services**

**Has this client previously received eating disorders treatment?** ☐ No ☐ Yes

If so please specify: _____

Date: _____ Location: _____

Current Weight:_____ ☐ lbs ☐ kg Current Height:_____ ☐ cm ☐ inches BMI:_____

Heart Rate:_____ Blood Pressure: _____ Date of reading:_____

Lowest Weight:_____ ☐ lbs ☐ kg Date:_____ Date of last menstrual

Highest Weight:_____ ☐ lbs ☐ kg Date:_____ period:_____

*For clients 18yrs and under please attach a growth chart* ☐ no growth chart available

**Weight Control Methods**

| **Please indicate all that apply** | **Frequency** | **Duration** |
|---|---|---|
| Food intake restrictions | | |
| Binge Eating | | |
| Induced vomiting | | |
| Laxative use | | |
| Exercise Quantity (per week) | | |
| Chewing and Spitting | | |
| Diet Pills | | |
| Substance Use | | |
| Other | | |

☐ ECG *(completed within the last 30 days)* ****MANDATORY**

**Lab results ****MANDATORY – results must be completed within the last 60 days**

| | | |
|---|---|---|
| ☐ Glucose | ☐ Amylase | ☐ RBC Folate |
| ☐ Vitamin B12 | ☐ Magnesium | ☐ Phosphate |
| ☐ Urea | ☐ Creatinine | ☐ CBC & Differential |
| ☐ Albumin | ☐ FSH | ☐ LH |
| ☐ Estradiol | ☐ AST | ☐ ALT |
| ☐ GGT | ☐ Alkaline | ☐ Phosphatase |
| ☐ Bilirubin | ☐ TSH | ☐ Sodium (Na+) |
| ☐ Potassium (K) | ☐ Calcium (Ca2+) | ☐ Ferritin |