Interlake–Eastern Regional Health Authority

Primary Care Direct Access to Psychiatry Consultation Program REFERRAL FORM

Date of Referral: ____ / ____ / ____
MMM DD YYYY

Please consider calling the RACE line (Rapid Access to Consultative Expertise) at 204-940-2573 for same day phone advice from a psychiatry consultant prior to referring your patient.

Did you consult RACE? ☐ Yes ☐ No When: ____ / ____ / ____
MMM DD YYYY

The PRIMARY CARE DIRECT ACCESS TO PSYCHIATRY CONSULTATION PROGRAM:

- Receives and triages referrals for non-urgent outpatient psychiatric assessment.
- Provides consultation service for patients 18 years of age and older who are residents of the Interlake-Eastern RHA.
- Provides assessment and treatment recommendations to the primary health care provider.
- Requests all pertinent health records be provided at the time of referral.
- Does not provide 3rd party assessment for the purpose of insurance, court, custody, etc.
- Offers services in person, by videoconference, or by telephone.

*** Individuals involved with the Community Mental Health Program, including Shared Care or Brief Treatment Program with the Selkirk and Area My Health Team or Ashern/Hodgson Area My Health Team have access to psychiatric consultation through that service.**

INDIVIDUAL' S CONTACT INFORMATION

Individual's Name: _____ Date of Birth: ____ / ____ / ____
MMM DD YYYY

Individual's Address: _____

Manitoba Health Card Number: _____ PHIN: _____

Primary Phone: _____ Secondary Phone: _____

Language of Service: ☐ English ☐ French ☐ Other: _____ Is an interpreter required? ☐ Yes ☐ No

Does the individual have any accessibility needs? _____

Is the individual aware of the referral? ☐ Yes ☐ No

REFERRAL INFORMATION

☐ Diagnostic Clarification ☐ Treatment Recommendations

Other: _____

What problems/symptoms is the individual having now that require assessment?

CURRENT MENTAL HEALTH CONCERNS

☐ Anxiety ☐ Depression ☐ Racing Thoughts ☐ Unstable Relationships ☐ Trauma

☐ Compulsive Behaviours ☐ Trouble Concentrating ☐ Paranoia ☐ Sudden Emotional Changes

Other: _____

Interlake–Eastern Regional Health Authority

Individual's Name: _____ DOB: ____ / ____ / ____
MMM DD YYYY

SUICIDE RISK ASSESSMENT

Is the individual having thoughts of suicide or self harm? ☐ Yes ☐ No If yes, within the past month? ☐ Yes ☐ No

Has the individual had a past suicide attempt? ☐ Yes ☐ No If yes, date(s): _____

IF THE INDIVIDUAL IS HAVING THOUGHTS OF SUICIDE or SELF-HARM, ENSURE THAT CRISIS SERVICES ARE UTILIZED AS NEEDED.

Is the individual pregnant or postpartum? ☐ Yes ☐ No Estimated or actual delivery date: ____ / ____ / ____
MMM DD YYYY

SUBSTANCE USE HISTORY ☐ None

Substance	Current	Past	Substance	Current	Past
Alcohol	☐	☐	Crystal Methamphetamine	☐	☐
Cannabis	☐	☐	Illicit Methadone	☐	☐
Cocaine	☐	☐	Misuse of Prescription Medication	☐	☐
Heroin	☐	☐	Misuse of Over the Counter Medications	☐	☐

Other (please specify): _____

Has the individual sought help with their substance use? ☐ No ☐ Yes (explain) _____

Does the individual want help with their substance use? ☐ No ☐ Yes

MEDICAL INFORMATION

MEDICATION: ***Please clearly indicate all current and/or past psychiatric medications and all other current medications; attach a separate sheet if more space is required. If the individual has no current or past medications, please indicate this below. (Mandatory Field – referrals will not be processed without this information).***

Current Medications	Dose	Frequency	Date Started

Past Psychiatric Medications	Dose	Frequency	Date Started & Discontinued

Interlake–Eastern Regional Health Authority

Individual's Name: _____ DOB: ____ / ____ / ____
MMM DD YYYY

PSYCHIATRIC TREATMENT HISTORY

Previous Counselling/Therapy (Cognitive Behavioural Therapy, supportive counselling, etc.):

_____

Please provide any pertinent records you have on file (discharge summaries, previous assessments, etc.) or request them with the individual's consent.

☐ No previous psychiatric diagnosis ☐ Previous psychiatric hospitalization at: _____

☐ Previous mental health contact (explain): _____

☐ Current or previous psychiatric diagnosis (explain): _____

☐ Current mental health supports (Psychiatrist, Psychologist, Community Mental Health Worker, Therapist, etc.):

_____

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

_____

_____

INTELLECTUAL DELAY/COGNITIVE IMPAIRMENT: *(provide all relevant testing and documentation)* ☐ No ☐ Yes

_____

INVOLVED WITH COMMUNITY LIVING disABILITY SERVICES (CLDS): ☐ No ☐ Yes

CLDS Staff Name: _____

BRAIN/HEAD INJURY: *(provide all relevant testing and documentation)* ☐ No ☐ Yes

_____

CURRENT/HISTORY OF VERBAL OR PHYSICAL AGGRESSION: ☐ No ☐ Yes

Please describe: _____

SOCIAL SITUATION: Please check all that apply.

☐ Stable Living Situation ☐ Unstable Living Situation ☐ Lives Alone ☐ Lives with Family/Partner/Other

☐ Assisted Living ☐ Group Home ☐ Homeless ☐ Shelter ☐ Other: _____

☐ Employed ☐ Unemployed ☐ Disability Income ☐ Employment & Income Assistance ☐ Self-Supported ☐ Student

OTHER PERTINENT INFORMATION (family history of mental health issues, family issues, other stressors)

Interlake–Eastern Regional Health Authority

Individual's Name: _____ DOB: ____ / ____ / ____
MMM DD YYYY

LEGAL INFORMATION

Does the individual have any outstanding charges? ☐ Yes ☐ No ☐ Unknown

If yes, state the charges and indicate any upcoming court dates: _____

Is the individual currently on probation? ☐ Yes ☐ No ☐ Unknown

If yes, please indicate duration and any upcoming court dates: _____

REFERRING PRIMARY HEALTH CARE PROVIDER

Name: _____

Phone #: _____ Fax #: _____

As the referring Primary Health Care Provider, I hereby commit to follow this individual in the community.

_____ Date: _____
SIGNATURE OF REFERRING PRIMARY HEALTH CARE PROVIDER

Please fax the completed referral form to Interlake-Eastern RHA Central Intake at 204-785-4870

or

TASK the Mental Health Intake role on the Interlake-Eastern RHA's EMR.

Please print clearly. Please note that incomplete and/or illegible forms will not be processed and will be returned.

Questions?

Please feel free to contact us by phone at 204-785-7752 x 1 or by tasking the Mental Health Intake role on the Interlake-Eastern RHA's EMR.