ADULT (18-64) URGENT CONSULTATION SERVICE (UCS)
MENTAL HEALTH AND ADDICTIONS REFERRAL FORM

PHONE: 519-667-6777 FAX: 519-667-6685

Our service is not able to provide immediate support in an emergency; however, we are able to see patients within 1-2 weeks. If your client is experiencing a mental health crisis and requires immediate help – advise them to contact REACH OUT (24-hour crisis line): 519-433-2023; or go to their nearest emergency department, or the Canadian Mental Health Association's Crisis Centre located at 648 Huron St. in London.
If your client requires a non-urgent referral, please see the Adult (18-64) Ambulatory Mental Health and Addictions Referral Form.

Our program provides an interprofessional, collaborative service between London Health Sciences Centre (LHSC) and St. Joseph's Heath Care (SJHC) London. Our goal is to provide an urgent, consultative care model for clients with limited follow-up and to coordinate access to available resources within LHSC and the community, as appropriate.

☐ If you are a specialist submitting this form, Primary Care Physician has been informed of this referral

☐ Patient does not have a family physician

Inclusion Criteria

- Individuals ages 18 to 64 (Early Intervention/First Episode Programs provide treatment to youth aged 16 and older)
- Serving residents of London and Middlesex County
- Patient has a primary care provider or has seen a physician at a walk-in clinic who is agreeable to follow up on recommendations provided

Was this referral discussed with the client? ☐Yes☐ No

Is the client willing to accept services? ☐ Yes ☐ No

Exclusion Criteria

- Court/legal/insurance purposes: Competency Assessment, Forensic Assessments, or involvement to satisfy third-party requests

Client Information

Last Name:_____

First Name:_____

Preferred Name:_____DOB:_____

Preferred Pronoun: _____

OHIP #:_____VC: _____

Current Address:

City:_____Postal Code: _____

Is interpretation required? ☐ Yes ☐ No
If yes, what language: _____

Personal Phone #: _____

Alternate Phone #: _____

Does client have a Substitute Decision Maker? ☐Yes ☐ No

SDM name and contact info: _____

Does client have a community treatment order?☐Yes ☐ No

Reason for Referral and Goals for Treatment

Reason/Goals for Referral (Required): _____

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Medication List (Required): _____

Client Name:

Previous Mental Health Treatment / Hospitalizations

(Attach psychiatric and diagnostic history, including consult/progress notes, admission notes, discharge summaries, etc.)

☐ It is mandatory to send the list of all current and previous medication trials otherwise referral will be returned

☐ See attachments ☐ See Clinical Connect

Current Safety Risk Factors (Assess and check all that apply)

☐ Active suicidal thoughts ☐ Passive suicidal thoughts ☐ History of suicide attempt(s)

☐ Thought to harm others ☐ History of violence/aggression ☐ Current intentional self-harm behaviours

☐ Behaviour influenced by delusions/command hallucinations ☐ Other, **please** specify:

Presenting Symptoms *Check all that apply and provide details below

Primary diagnosis, if known: _____

☐ Depressed Mood ☐ Mania/Hypomania ☐ Anxiety/Panic ☐ Post-traumatic stress ☐ Psychosomatic Symptoms

☐ Gender Dysphoria ☐ Disruptive/Impulse Control Concerns ☐ Personality Disorder Symptoms ☐ OCD ☐ ADHD

☐ Psychotic Symptoms ☐ Eating Disorder ☐ Current substance abuse, specify: _____

☐ Please Provide Details: _____

Referring Source Information

Referring Physician:_____Billing #:_____

Phone #:_____Fax #: _____

Office Address: _____

City:_____Postal Code: _____

Signature: _____

Date: _____

If you have any inquiries or require clarification regarding this referral form, please contact the Centralized Access Point (CAP), Ambulatory Mental Health and Addictions Program at LHSC (519-685-8500 ext. 76777) during business hours (Monday through Friday from 8:30 a.m. – 4:30 p.m., excluding holidays).

To submit this referral send the completed referral form and relevant attachments to the Centralized Access Point Office at LHSC
FAX: 519-667-6685