Date Received

Account Number

Waypoint Centre for Mental Health Care Referral
Outpatient, Consultation & Housing Services

If you have any questions about the referral process, please call Waypoint Centre for Mental Health Care Central Intake at 705-549-3181 ext.2308, press 4.
Based on the information provided on the referral, the Waypoint Central Intake team will match the patient needs to services.
Visit our website for a list of services, programs and criteria.

Referral Requirements – a referral cannot be processed without the following.

1. **Physician/nurse practitioner** – referral is required for most Waypoint services
2. **Psychiatric diagnosis or consultation request for diagnostic clarification**
3. **Medications** – a current list of medications
4. **Risk Identification** – at the time of the referral the patient risks are documented
5. **Labs and Diagnostics** – recent and relevant lab work as well as diagnostic reports
6. **Consultations** – previous psychiatric consultations and discharge summaries
7. **Medical Diagnosis/Problems** – list of medical diagnosis and problems
8. **Transitional Age Youth Referrals** – Transitional Age Youth Psychiatric Consultation Service Self Report is required
9. **Homes for Special Care Program –** requires additional documentation found here

Referral Source Information

Referral source name:	Date *(dd/mm/yyyy)*:
Relationship to client/patient?	
If referral completed by not completed by primary care provider please complete the field below.	
Primary care provider name:	Aware of referral? ☐ yes ☐ no
Telephone #:	Fax #:
Referral completed by:	Contact #:
Referral source signature:	

Your submission of this referral form will be taken to explicitly mean that you have obtained appropriate permissions for releasing the information contained in this referral form to Waypoint Centre for Mental Health Care (the agencies) and Services to whom you are submitting this referral form. If applicable, please include your Organization's Consent to Release of Personal Health Information Form.

Client/Patient Information

Last name, first name:	
Preferred name:	DOB *(dd/mm/yyyy)*:
Address:	
Gender: ☐ Female ☐ Male ☐ Intersex ☐ Trans (male to female) ☐ Trans (female to male) ☐ Two Spirit ☐ Other:	
Interpreter required? ☐ yes Language:	
Health card number:	Version code:

Consent

(Indicate Yes or No in each section if patient is able to provide consent)

	Medical treatment		Finances		Release of personal health information
	Psychiatric treatment		Sexual consent		

Contact Information

Contact name:	☐ Patient/client ☐ SDM ☐ Other
Telephone #:	☐ Cell ☐ Home ☐ Work
Telephone #:	☐ Cell ☐ Home ☐ Work
Permission to leave voice mail? ☐ yes ☐ no	

Referral Information

Psychiatric diagnosis:

Name of patient's psychiatrist?

Reason for referral: *(Goals for referral, current/presenting symptoms, relevant psychiatric history, previous interventions tried)*

Substance use: *(Current substances, amount, frequency)* Does patient want help with this issue? ☐ yes ☐ no

Cannabis use? ☐ yes ☐ no ☐ prescription

Relevant medical/developmental history:

Current supports and services: *(List all current supports and services and contact info)*

Personal hygiene: ☐ Independent ☐ Needs prompts ☐ Needs assistance

Senses: ☐ Visual impairment ☐ Hearing impairment

Communication: ☐ Receptive challenge ☐ Expressive challenge

Ambulation: ☐ Without assistance ☐ With assistance ☐ Unsteady ☐ Wheelchair/walker

Other equipment:

Eating: ☐ Independent ☐ Requires prompts ☐ Requires assistance

Legal Involvement

Current charges? ☐ yes ☐ no Probation? ☐ yes ☐ no

Community Treatment Order? ☐ yes ☐ no Expiry date *(dd/mm/yyyy)*

Other?

Current Patient/Client Risks

Describe your patient/client's current risks in the following categories

Risk of Harm:

Functional Status:

Medical, Addictive and Psychiatric Co-Morbidity:

Levels of Stress:

Level of Support:

Treatment and Recovery History:

Engagement and Recovery Status:

Medication List

Include prescription, vitamins, over the counter medications and herbal supplements

Medication	Dose/Units	Route	Frequency	Instructions/Comments
☐ See attached Medication List/copy of Medication Administration Record				