Mental Health & Addictions
Adult Outpatient Services

835 King Street West
Kitchener, ON N2G 1G3
https://www.grhosp.on.ca/

PSYCHIATRIC CONSULTATION CLINIC REFERRAL

Adult Outpatient Mental Health Services

FAX Referral To: 519-749-4456

PHONE: 519-749-4300 Ext. 3968 (clerical), 2374 (nursing)

SECTION 1 – Overview

Centralized Intake

- referrals may be declined if each section of the referral is not completed in full
- referring physicians will be notified of referral acceptance and approximate wait time
- referring physicians and patients will be notified of scheduled appointment
- it is the responsibility of the referring physician to notify the clinic when the patient's contact information changes

Overview of Psychiatric Consultation Clinic (PCC)

- for patients requiring diagnostic clarification, one-time consultation only; this clinic does not offer follow-up care
- treatment recommendations provided to the referring physician
- patients 18 years and older residing in Grand River Hospital's catchment area (Kitchener, Waterloo, Wellesley, Wilmont, Woolwich, Ayr, Blair, Branchton, Roseville, Wrigley Corners)
- patients may be offered virtual or in-person consultations, depending on physician availability
- missed appointments (no-shows) **will not** be rebooked

SECTION 2 – Criteria

The Psychiatric Consultation Clinic will not accept referrals for the following:

- Attention Deficit Hyperactivity Disorder (ADHD)
- Autism Spectrum Disorder (ASD)
- Third-party requests (e.g., court assessments, insurance assessments, etc.)
- Valid and updated Health Card is required

IMPORTANT – If your patient is **in crisis**, please consider the following options:

HERE 24/7 Addiction, Mental Health & Crisis 1-844-437-3247

Grand River Hospital Emergency Department

Waterloo Regional Police

DATE OF REFERRAL: Click or tap to enter a date.

SECTION 3.a. – Referring Physician Information *please complete in full, no stamps*	
Physician Name:	
Phone:	**Fax:**
Office Location (City):	
Billing #:	**CPSO #:**
Signature:	**Date:** Click or tap to enter a date.

SECTION 3.b. – Primary Care Provider		
	YES	**NO**
Is the referring physician the same as the PCP?	☐	☐
If **no,** please provide full name of PCP:		

SECTION 4 – Patient Information *please ensure this is up-to-date, no patient labels*			
Full Legal Name:			
Preferred Name:			
Sex:	☐Male ☐Female ☐Other ☐Unknown		
Gender:	☐Man ☐Woman ☐Two spirit ☐Non-binary ☐Prefer not to say ☐None of the above:		
Personal Pronouns:			
DOB: Click or tap to enter a date.			
OHIP Number:		**Version Code:**	
Street Address:			
City:	**Province:**	**Postal Code:**	
Preferred Phone Number:			
Alternate Phone Number:			
Does the patient consent for a confidential voicemail to be left? ☐Yes ☐No			
Email Address:			
Does the patient consent to GRH using their email? ☐Yes ☐No			
Preferred Pharmacy:			
Does the patient require translation services? ☐Yes ☐No			
If yes, what is the language of origin?			
Is the patient at risk of falling? ☐Yes ☐No			

SECTION 5 – Current and Past Psychiatric Diagnoses		
	PAST	PRESENT
Anxiety Disorders	☐	☐
Bipolar Disorders	☐	☐
Depressive Disorders	☐	☐
Neurocognitive Disorders	☐	☐
Personality Disorders	☐	☐
Psychotic Disorders	☐	☐
Substance-Use Disorders	☐	☐
Trauma & Stressor Related Disorders	☐	☐
Other, please specify:		

SECTION 6 – Current Psychiatric Signs and Symptoms			
☐	Abnormal eating behaviour	☐	Hallucinations
☐	Agitation/Aggression	☐	Intellectual disability
☐	Anxiety	☐	Memory impairment
☐	Attention deficit/hyperactivity	☐	Obsessive thoughts
☐	Compulsive behaviour	☐	Panic symptoms/attacks
☐	Confusion	☐	Personality problems
☐	Delusions	☐	Phobias
☐	Depressed Mood	☐	Sleep disturbance
☐	Disorganized thought processes	☐	Suicidal thoughts/actions/behaviours
☐	Elevated Mood	☐	Unusual behaviour
☐	Fluctuating Mood		
Other, please specify:			

SECTION 7 – Risk Assessment: Current and Past			
	PAST	PRESENT	COMMENTS
Suicide Attempts	☐	☐	
Suicidal Ideation	☐	☐	
Self-Harming Behaviour	☐	☐	
Homicidal Ideation	☐	☐	
Violent Behaviour	☐	☐	
Substance-Use Disorders	☐	☐	
Legal System Involvement	☐	☐	
Other, please specify:	☐	☐	

SECTION 8 – Housing			
☐	Private Residence, self	☐	Shared Accommodations
☐	Private Residence, spouse/children	☐	NFA/Shelter
☐	With Adult Children as Caregivers	☐	Unknown

SECTION 9 – Community Supports	YES	NO
Does the patient have support in the community? If **yes,** please specify.	☐	☐
Social Worker	☐	
Mental Health Nurse	☐	
Other, please specify:		

SECTION 10 – Psychosocial Concerns			
☐	Accommodation	☐	Lack of Social Supports
☐	Anger Management	☐	Legal Issues
☐	Bereavement/Grief	☐	School Stressors
☐	Caregiver Responsibilities	☐	Workplace Stressors
☐	Coping Challenges	☐	Unemployment
☐	Financial Issues		
Other, please specify:			

SECTION 11 – Medication	YES	NO
Is there a history of medication non-compliance?	☐	☐
Does the patient need assistance to take medication?	☐	☐
Is the patient **currently** prescribed psychiatric medication?	☐	☐
Has the patient **previously** been prescribed psychiatric medication?	☐	☐
If **yes,** please list or attach current medications:		

SECTION 12 – Relevant Medical History											
Please attach a copy of the most recent bloodwork results.											
Does the patient have any of the following conditions?											
☐	CAD	☐	CHF	☐	Diabetes	☐	HTN	☐	Neurological	☐	Seizure Disorder
Other, please specify:											