

Referral to the Nurse Practitioner Led Clinic

Patient Contact Information:

First Name _____ Last Name _____ Phone Number (permission to leave message ☐) _____

Health Card Number _____ Date of Birth: ____/____/____ DD MM YYYY

Address _____ City _____ Postal Code _____

Gender: ☐ Male ☐ Female Language Spoken: _____

Psychiatrist: _____

Current Pharmacy: _____

Mental Health Diagnosis and/or alerts: _____

Allergies: _____

RISKS:

- | | | |
|--|--|---|
| ☐ Violence towards others | ☐ Sexual aggression | ☐ Concealing weapons |
| ☐ Violence towards self | ☐ Suicide | ☐ Fire-setting |
| ☐ Violence towards property | ☐ Falls (if yes, please describe functional mobility/ assistive devices): _____ | |
| ☐ Any other risks: _____ | | |

Legal Involvement/ Status: (if no legal involvement, leave this section blank)

- | | |
|---|--|
| ☐ Criminal record | ☐ NCR |
| ☐ Current charges (if yes, please describe): _____ | ☐ Past charges (if yes, please describe): _____ |

Reason for Referral:

- ☐ Needs a Primary Care Provider ☐ Clozapine Monitoring ☐ Depot Injection Clinic

Referral Source Contact Information (must be included):

Name: _____ Contact Number: (____) _____

Date of Referral: _____ (mm/dd/yy)

We are happy to accept this referral provided that you have included ALL necessary information:

For Depot:

- | | |
|--------------------------------------|-----------------------|
| 1.) Prescription for Depot Injection | 3.) Date of last dose |
| 2.) Medication Reconciliation | 4.) Discharge Summary |

For Clozapine:

- | | |
|---|-------------------------------|
| 1.) CSAN # with ordered frequency of lab work | 3.) Medication Reconciliation |
| 2.) Most recent ECG | 4.) Discharge Summary |

***Please fax this form to the Nurse Practitioner Led Clinic Receptionist at (905) 436-9313.**