Canadian Mental Health Association Durham
Helping people move forward

Nurse Practitioner Led Clinic
60 Bond Street West, 2nd Floor
Oshawa, Ontario
Tel: (905) 436-9945
Fax: (905) 436-9313

Referral to the Nurse Practitioner Led Clinic

Patient Contact Information:

_____ _____ _____
First Name *Last Name* *Preferred Name*

_____ _____/_____/_____
Phone Number (permission to leave message ☐) *Date of Birth:* DD MM YYYY

_____-_____-_____-_____ _____
Health Card Number *Allergies*

_____ _____ _____
Address *City* *Postal Code*

Gender: _____ Language Spoken: _____

Psychiatrist: _____

Current Pharmacy: _____

Mental Health Diagnosis and/or alerts: _____

HISTORY OF RISKS:

☐ Violence towards others ☐ Sexual aggression ☐ Concealing weapons
☐ Violence towards self ☐ Suicide ☐ Medication compliance
☐ Violence towards property ☐ Falls *(if yes, please describe functional mobility/ assistive devices)*:_____

☐ Any other risks (e.g. fire setting)_____

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/YYYY)

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

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

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

Please fax this form to Community Connection Services at 905-436-1569