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

Referral to the Nurse Practitioner Led Clinic

PATIENT INFORMATION

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

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

Sex: _____ *Gender*: _____ Language Spoken: _____

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

_____ _____ _____
Address *City* *Postal Code*

☐ No Fixed Address/Homeless

REASON FOR REFERRAL

☐ **Needs a Primary Care Provider**

Specify Past Primary Care Provider: _____

Last Appointment With Above Provider:_____

☐ **CANDID Program**

Specify Palliative or Life-Limiting illness: _____

☐ **Clozapine Monitoring**

***You *must* provide**

1. CSAN # with ordered frequency of lab work
2. A Baseline ECG
3. Recent Medication List
4. Discharge Summary

☐ **Depot Injection Services**

***You *must* provide**

1. A Prescription for Depot Injection
2. Date of Last Dose
3. Recent Medication List
4. Discharge Summary

☐ **Trans Health Care Services**

Over ⟶

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

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CIRCLE OF CARE

Psychiatrist: _____

Current Pharmacy: _____

Other: _____

RISK ASSESSMENT

- ☐ Hx Violence Towards Others
- ☐ Hx Violence Towards Self
- ☐ Hx Violence Towards Property
- ☐ Falls *(if yes, please describe functional mobility/assistive devices)*:

_____

- ☐ Sexual Aggression
- ☐ Hx Suicide Attempt
- ☐ Other_____

- ☐ Hx Concealing Weapons
- ☐ Hx Fire-Setting

☐ None

LEGAL INFORMATION *(if no legal involvement, leave this section blank)*

- ☐ Criminal record
- ☐ Current charges *(if yes, please describe)*:

_____

- ☐ NCR
- ☐ Past charges *(if yes, please describe)*:

_____

☐ None

REFERRAL SOURCE

☐ ***I am referring myself*** ☐ ***I am referring someone else with their consent***

Your Name: _____

Your Phone Number: (_____) _____ Fax Number (if applicable): _____

Relationship to the person being referred: _____ Date of Referral:_____

We will confirm processing of this referral provided that you have included ALL requested information.

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