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*

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

_____ *Health Card Number & Version Code*
_____ *Allergies*
_____ *Diagnosis*

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

_____ ☐
Email Address (check for permission to communicate via email)

_____ *Address*
City
Postal Code

No Fixed Address: ☐

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**

☐ **Psychiatrist Consult**
You must provide:
Email Address: _____
Primary Care Provider & Number: _____
Verbal Consent for CMHA to contact Primary Care Provider: ☐

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

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CIRCLE OF CARE

Current Doctor/Primary Care Provider:_____

Psychiatrist:_____

Other Practitioners:_____

Current Pharmacy: _____

RISK ASSESSMENT

- ☐ Hx Violence Towards Others
- ☐ Hx Violence Towards Self
- ☐ Hx Violence Towards Property
- ☐ Sexual Aggression
- ☐ Hx Suicide Attempt
- ☐ Other:_____
- ☐ Hx Concealing Weapons
- ☐ Hx Fire-Setting
- ☐ Falls *(if yes, please describe functional mobility/assistive devices)*:

_____

☐ 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