



Hôpital général de Nipissing Ouest
West Nipissing General Hospital

ALLIANCE CENTRE

172 Ethel St, Box D1
Sturgeon Falls, Ontario P2B 1V9
Tel: 705-753-2271/ Fax: 705-753-4202

REFERRAL FORM

****Individual must be 16 years of age and reside within the Municipality of West Nipissing to qualify for services****

Referral Source _____ Telephone: (____) _____ - _____

Name _____ Date of Birth _____

Address _____

Telephone Number _____ Language Preference _____

Permission to leave message: Yes No

Permission to send correspondence: Yes No

Family Physician: _____ Psychiatrist: _____

Other Agencies/Services Currently Involved with individual:

Diagnostic Categories - Please provide as much information as possible

- | | |
|---|--|
| <input type="checkbox"/> Adjustment Disorder | <input type="checkbox"/> Factitious Disorders |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Mental Disorders due to General Medical Condition |
| <input type="checkbox"/> Mood Disorders | <input type="checkbox"/> Somatoform Disorders |
| <input type="checkbox"/> Disorder of Childhood/Adolesc. | <input type="checkbox"/> Personality Disorders |
| <input type="checkbox"/> Dissociative Disorders | <input type="checkbox"/> Schizophrenia and other Psychotic Disorders |
| <input type="checkbox"/> Substance Related Disorders | <input type="checkbox"/> Unknown |

Most Recent Psychiatric Diagnosis: _____

Previous Psychiatric Hospitalization(s): _____

Presenting Issues:

- | | |
|---|---|
| <input type="checkbox"/> Threat to others/attempted suicide | <input type="checkbox"/> Financial |
| <input type="checkbox"/> Specific symptom of serious mental illness | <input type="checkbox"/> Legal |
| <input type="checkbox"/> Physical/Sexual Abuse | <input type="checkbox"/> Problems with relationships |
| <input type="checkbox"/> Educational | <input type="checkbox"/> Problems with substance abuse/addictions |
| <input type="checkbox"/> Occupational/Employment/Vocational | <input type="checkbox"/> Activities of Daily living |
| <input type="checkbox"/> Housing | <input type="checkbox"/> Other |

Medical Issues:

- Significant Medical/Physical Illness _____
- Chronic Pain _____
- Physical Symptoms Other Than Chronic Pain _____
- Medication Issues _____
- Other _____

Current Medication(s):

Intervention Requested:

<input type="checkbox"/> Mental Health Counselling and Treatment	<input type="checkbox"/> Substance Abuse Counselling Services
<input type="checkbox"/> Intensive Case Management Services	<input type="checkbox"/> Substance Abuse Counselling for Significant Others
<input type="checkbox"/> Psychiatric Consultation	<input type="checkbox"/> Addictions Medicine Program (RAAM)

Additional Comments:

Signature: _____

Date: _____