Clear Form

Outpatient Psychiatry Services Referral Form

☐ Adult Outpatient Psychiatry
☐ Abegweit First Nation Wellness Centre
☐ Brackley Stables
☐ Child & Youth Outpatient Psychiatry (<18 years)
☐ Lennox Island Health Centre
☐ Community Outreach Centre - Charlottetown

Patient is aware and agreeable to this referral ☐ Yes ☐ No

Is there a specific barrier as to why the patient cannot receive Tele-psychiatry services? If yes, provide details.

Please note:
To access Outpatient Psychiatry Services, please complete this referral form and provide all required documentation. This referral should be used to access Outpatient Psychiatry Services EXCEPT in the following cases:

- CMH Outreach Programs
- Seniors Mental Health Resource Team Programs
- Therapy Services – refer to CMH
- Emergencies – We do not provide emergency psychiatry services
- Patients will not be seen primarily for legal or quasi-legal issues (WCB, Disability Assessments, Family Court, report to the court, report to probation, capacity assessments).
- Not for primary assessment of Adult Autism Spectrum Disorder (https://starsforlife.com/), Adult Attention-Deficit/Hyperactivity Disorder (https://www .upei.ca/adhd-clinic), or Substance Abuse/Addictions

Referral Source Information	
Name:	Phone:
Patient Information	
Name:	Phone:
DOB: Age:	PHN:
Preferred pronouns:	Marital Status:

Patient has a primary care provider (Family Practitioner/NP)? ☐ Yes ☐ No

Is the Primary Care Provider aware of this referral? ☐ Yes ☐ No

Is a translator required? ☐ Yes ☐ No

If yes, identify language:

NOTE Family members cannot act as formal translators.

Is this patient currently receiving services through Community Mental Health and Addictions or private counseling services? ☐ Yes ☐ No

If Yes, provide details:

Reason for Consult

☐ This referral is intended for pharmacological recommendations.

☐ This referral is intended for psychiatric diagnostic and treatment recommendations.

Provide specifics:

Prior Psychiatric History

Substance Use

List past and present substance use, including alcohol, marijuana:

List Prior Medical Illness

(Chronic and Acute, Surgeries, and Diagnostics)

Medications:

List current psychiatric medications and any other psychiatric medication trials including dosages and results:

List non- psychiatric medication including dosages:

Allergies

Risks – select all that apply:

☐ None

Suicide attempts

☐ 31-60 days ☐ 61-90 days ☐ 91+ days

☐ Suicidal ideation (within the last 6 mos)

☐ Deliberate Self-harm (non-lethal within the last 6 mos)

☐ Violent Behaviour / Safety Concerns (within the last 6 mos).

Communication Preferences

By providing an email and/or cell number preferences, you confirm the patient has consented for Outpatient Psychiatry Services to email and/or text appointment details and portal notifications and is aware that email and/or texting is not a secure method of transmission.

Consent to receive emails from patient portal to the Primary Preferred Email (as indicated above)

☐ Yes ☐ No

Send appointment reminders to:

Primary preferred cell phone:

Primary preferred email:

Information for the patient and referral source

Outpatient Psychiatry Services will make two attempts to contact the client. If unsuccessful, a letter will be issued to the patient allowing 15 days for a response. If there is no response at the end of the 15-day period, the referral will be closed.

If this referral is requested for services other than pharmacological recommendations, please confirm the patient is referred or has self-referred to CMH for additional support.

☐ Confirmed