VILLAGE
Family Health Team

Dear Referring Source,

Village Family Health has a special interest to provide primary care to people with mental illness and addictions. We have developed a referral process in collaboration with CAMH to ensure a warm connection to a primary care provider. We require that the referring source ensures that the patient's psychiatric needs are met and planned for. Please ensure the following conditions are met and check beside each box:

- ☐ The patient is stable from a psychiatric perspective or will receive ongoing psychiatric treatment
- ☐ The patient lives within our catchment area of Parkside, Dupont, University & Lakeshore
- ☐ The most recent psychiatric consult note is included with the referral form
- ☐ A full medication list is included with the referral form
- ☐ Discharge summaries, if applicable, are included
- ☐ The Village Family Health Team Referral Form is completed in full

Failure to provide any of this information will result in the return of the referral to you. We thank you for your collaboration.

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CAMH Referral Form to Village Family Health Team
Fax To: 416 599 2001 Attention: Social Work
Revised **07/11/2016**
Patient **Must** live within the catchment area of: Parkside to University, & Lakeshore to Dupont
Please append **consult notes**, **medication list**, and/or **discharge report** to this referral.

Patient Information:

First name____________________________ Last name___________________________________
Date of Birth ____________________________

Health Card & Version Code # ____________________________ *(Patient must have a valid healthcard)*

Street Address ___________________ Apt #_______________________
Postal Code _____________________ *(Patient must live in the catchment area at the top of this form)*
Home Phone # __________________________ Cell # __________________________

Case Worker Name _______________________ Case Worker's Phone # ___________________________
Case worker's email address _____________________________

Psychiatrist Name _________________________ Psychiatrist's Phone #________________________
Psychiatrist's email address _____________________________________

Patient's Pharmacy/Pharmacist ___________________Pharmacy Phone #___________________________

Referred By:

Name: __________________________ Date:_____________________
Phone # _________________________ Email address _________________________________
CAMH Program _______________________________

Additional Information:

Primary Physical Health Diagnosis:
____

Primary Mental Health and/or Addiction Diagnosis:
____

Current medication (attach list if necessary):
1)._________________________ 2). _________________________________
3). ___________________________ 4). _________________________________
5). ___________________________ 6). _________________________________

CAMH Psychiatry will continue to follow this patient: Yes No
If yes, describe the proposed plan including name/contact # of psychiatrist to share the patient's care:
____
____

Appointments scheduling arrangements (circle one)

Contact patient Contact patient and Notify case worker Contact Case Worker