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 and 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

Please NOTE: If a patient has experienced suicidality, they are required to have on - going psychiatric follow up.

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