

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.

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