

North Bay Regional Health Centre

Regional Mental Health Referral Form

Complete form online, print, and
fax to 705-495-7843
Phone 705-495-7841
Website: www.nbrhc.on.ca

Addressograph

***Please note: We are not a crisis or emergency service. If your patient requires immediate attention and cannot wait for an assessment, please consider accessing the local emergency department.**

****Please note: Incomplete referrals will result in a delay as we cannot make a decision until all information is received**

Client Information

Health Link Client Yes No

Last Name: _____ First and Middle Name: _____
Health Card Number: _____ Version: _____ Expiry Date (dd/mmm/yyyy): _____
Date of Birth (dd/mmm/yyyy): _____ Gender: Female Male Other
Current Address: _____
City: _____ Province: _____ Postal Code: _____
Phone: _____ Preferred Language: _____

Housing

- | | |
|--|--|
| <input type="checkbox"/> Private Home/Apartment | <input type="checkbox"/> Long-Term Care Facility/Retirement Home |
| <input type="checkbox"/> Setting for person with intellectual disability | <input type="checkbox"/> Setting for person with physical disability |
| <input type="checkbox"/> Mental Health Residence | <input type="checkbox"/> Supportive (Board and Care) |
| <input type="checkbox"/> Correctional Facility | <input type="checkbox"/> Hospital |
| <input type="checkbox"/> Other (describe): _____ | |

Family/Caregiver/Next of Kin Information

Last Name: _____ First Name: _____
Address: _____ City: _____
Postal Code: _____ Phone: _____ Work: _____
Relationship: _____
Is this person identified as Substitute Decision Maker (SDM)? Yes No NA

Capacity to Consent

Client/SDM Agreeable to Referral: Yes No Client/SDM Consents to Referral: Yes No NA
Capacity to Consent to Treatment: Yes No NA
Capacity to Consent to Collection/Use/Disclosure of Personal Health Information: Yes No NA
Capacity to Consent to Manage Property/Finances: Yes No NA

Legal Status

- Voluntary
- Involuntary Form #: _____ Expiry Date: _____ Contesting Involuntary Form Yes No
dd/mmm/yyyy
- Community Treatment Order Expiry Date: _____
dd/mmm/yyyy

Substitute Decision Maker/Power of Attorney (complete **only if different from Next of Kin)**

Last Name: _____ First Name: _____
 Address: _____ City: _____
 Postal Code: _____ Phone: _____ Work: _____
 Relationship: _____

Reason for Referral

Factors Contributing to Referral (precipitating event, include current symptoms, and level of urgency):

Psychiatric Diagnosis(es) both known and suspected:

Medical Diagnosis/Active Treatment (please include active treatment i.e., IV)

Risks

- | | | |
|---|---|---|
| <input type="checkbox"/> Harm to Self | <input type="checkbox"/> Harm to Others | <input type="checkbox"/> Medication Non-adherence |
| <input type="checkbox"/> Suicide | <input type="checkbox"/> Sexual Aggression | <input type="checkbox"/> Wandering/Elopement |
| <input type="checkbox"/> Choking/Aspiration/Dysphagia | <input type="checkbox"/> Living Alone | <input type="checkbox"/> Arson/Fire Setting |
| <input type="checkbox"/> Weapons | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Alcohol Misuse |
| <input type="checkbox"/> Drug Misuse | <input type="checkbox"/> Tobacco/Nicotine Use | <input type="checkbox"/> Falls |

Community Supports Prior to Admission

Last Name: _____ First Name: _____
 Agency Name: _____
 Address: _____ City: _____
 Postal Code: _____ Phone: _____ Fax: _____

Last Name: _____ First Name: _____
 Agency Name: _____
 Address: _____ City: _____
 Postal Code: _____ Phone: _____ Fax: _____

Last Name: _____ First Name: _____
 Agency Name: _____
 Address: _____ City: _____
 Postal Code: _____ Phone: _____ Fax: _____

Preadmission Goals

Client:

Family:

Referent:

Service Specific Documentation Required (please attach)

Dual Diagnosis (Birch/Maple):

- Medication List
- Psychiatrist Notes/History
- Medical Assessments/Consultations
- Clozapine CSAN # (if applicable)

Psychiatric Rehabilitation (Nickel/Northern):

- Medication List
- Psychiatrist Notes/History
- Medical Assessments/Consultations
- Clozapine CSAN # (if applicable)

Geriatrics (Evergreen/Oak):

- Medication List
- Psychiatrist Notes/History
- Medical Assessments/Consultations

- BSO Summary
- Labs: delirium workup
- Care of the Elderly/Geriatrician/Geriatric Psychiatrist Consultation Note

Additional Supporting Documentation (if available)

- | | |
|--|---|
| <input type="checkbox"/> Diagnostic Imaging | <input type="checkbox"/> Functional Assessments |
| <input type="checkbox"/> Current Treatment Plan | <input type="checkbox"/> Psychological Assessments |
| <input type="checkbox"/> Nursing Summary (Progress Notes x 5 days) | <input type="checkbox"/> Psychosocial Assessment |
| <input type="checkbox"/> Concurrent Disorders | <input type="checkbox"/> Wellness Recovery Action Plan (WRAP) |
| <input type="checkbox"/> BSO Summary | <input type="checkbox"/> DSO/Supports Intensity Scale (SIS) |

Referring Physician

Name: _____
 Phone: _____ Fax: _____
 Primary Care Provider (if different from above): _____
 Phone: _____ Fax: _____ Aware of Referral? Yes No

Referral Completed By

Name: _____
 Agency: _____
 Phone: _____ Fax: _____
 Signature: _____ Date: _____
 Do you have access to videoconferencing? Yes No dd/mmm/yyyy

Complete and fax to 705-495-7843 or phone 705-495-7841

Website: www.nbrhc.on.ca

Office Use Only

Date Received: _____ Date Sent to Program: _____ Date of Decision: _____

Appendix

Prior to submitting your referral, ensure that you have completed all sections and indicate whether any supplementation documents are attached or will be following under separate cover.

Note: This interactive online form will create a printable PDF only. When completed you will need to save the resulting PDF file and/or print it. Signatures will be required prior to faxing to the North Bay Regional Health Centre – Central Referral. Completed referrals are **NOT** to be emailed; fax to **705-495-7843**. If you require additional information regarding the referral process, call 705-495-7841. The office is open 5 days a week from 8:00 a.m. to 4:00 p.m. (excluding statutory holidays).

NBRHC is Tobacco Free as of November 1, 2017. More information can be found on the NBRHC website at:
 English – <http://www.nbrhc.on.ca/tobacco-free/>
 French – <http://www.nbrhc.on.ca/fr/sans-tabac/>

Regional Inpatient Programs and Services that utilize this referral form are the following:	
Birch/Maple Lodge Dual Diagnosis Unit 14 bed unit	Age: 18+ Service Area: North East Region Referrals Accepted from: Psychiatrist, Primary Care provider Type of Service: Developmental/intellectual disability plus mental health concerns/behavioural challenges focus on the specialized needs of those functioning in the moderate to profound range of developmental disabilities. Services include providing assessment, stabilization, rehabilitation, transitional support to return 'home.'
Nickel Lodge Psychiatric Rehabilitation 16 bed unit Sudbury campus	Age: 18+ Service Area: North East Region Referrals Accepted from: Psychiatrist, Primary Care provider Type of Service: Specialized adult rehabilitation and transitional service providing care/support to those with severe mental illness/co-morbid condition.
Northern Lights Lodge Psychiatric Rehabilitation 16 bed unit	Age: 18+ Service Area: North East Region Referrals Accepted from: Psychiatrist, Primary Care provider Type of Service: Provides assessment and treatment and rehabilitation for individuals with complex and refractory problems. Following discharge, consultative services are provided by the Community Outreach Service.
Evergreen Lodge Geriatric Psychiatry 12 bed unit	Age: 65+ Service Area: North East Region Referrals Accepted from: Psychiatrist, Primary Care provider Type of Service: Provides comprehensive specialized assessment and treatment for older adults with complex age related psychiatric needs.
Oak Lodge Dementia Care 18 bed unit Sudbury campus	Age: 65+ Service Area: North East Region Referrals Accepted from: Psychiatrist, Primary Care provider Type of Service: Provides comprehensive specialized assessment/treatment of older adults and/or adults with age-related dementia complicated by behavioural, psychological and/or neurocognitive impairments that exceed capacity of community resources.