

# MENTAL HEALTH SERVICES – CENTRAL INTAKE

Telephone: 416.756.6642 Fax: 416.756.6671 <http://www.nygh.on.ca>

Visit the North York General Hospital website to download this form and to obtain program /service specific intake criteria.

***Mental Health Outpatient Program details/criteria, and the hospital cancellation policy are available at <http://www.nygh.on.ca>. Incomplete referrals will be faxed back and WILL DELAY the referral process.***

- Patients **must** be aware that referral has been made to the specific program/service.
- We do **not** provide child custody /access assessments.
- If this an Assertive Community Treatment Team, Mental Health and Justice Treatment and Support Services, or Mindfulness-Based Stress Reduction referral, **these programs have a separate referral form/process. Go to: <http://www.nygh.on.ca>** and click the Health Professionals link to access the referral forms.

(Specify clinic)  Adult Psychiatry (AMHOP-Physician referrals only)  Day Hospital  Day Treatment  Adult Addictions  
 Child / Adolescent Mental Health (CAMHOP-Physician referrals only)  Child/Adolescent Day Hospital (Physician referrals only)  
 Youth Addictions (16-24)  Other: (specify) \_\_\_\_\_

## PATIENT INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Referral Date: \_\_\_\_\_ Patient MRN# (if available): \_\_\_\_\_

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

DOB (yy/mm/dd): \_\_\_\_\_ OHIP #: \_\_\_\_\_

Primary Tel: \_\_\_\_\_ Can a message be left?  Voice Mail  With another person

Other Tel: \_\_\_\_\_ Can a message be left?  Voice Mail  With another person

Referring Physician/Healthcare Provider: \_\_\_\_\_ MD Billing #: \_\_\_\_\_

Address (Name of Agency if available): \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

\_\_\_\_\_  
*Referrer's Signature*

\_\_\_\_\_  
*Designation (Must be a physician for physician consults)*

## REASON FOR REFERRAL:

**MENTAL HEALTH ISSUES:** *Please include any information regarding violence, suicidality, active substance abuse or legal history (charges)*

**CURRENT MEDICAL CONDITIONS & MEDICATIONS:** *Please include dosages*