METANOIA HEALTH & WELLNESS

3089 Forest Glade Drive

Windsor, ON

N8R 1W6

(T) 519-916-0400 (F) 519-916-0488

ELIGIBILITY CRITERIA

- Must have a referral from a family physician or nurse practitioner
- Must be currently unattached from psychiatry services
- Must have a valid health card at the time of referral as all visits covered through OHIP
- By appointment only
- Consult consists of two visits – (1) Registered Nurse for intake assessment (2) Psychiatrist
- All consult notes with recommendations from psychiatrist to be sent directly to referring clinician
- No prescriptions to be given at the time of consult. Patient must return to referring clinician for follow up and implementation of wellness plan
- **NO URGENT OR CRISIS SERVICES PROVIDED**

CLIENT INFORMATION	**REFERRAL SOURCE**
LAST NAME: _____ FIRST NAME: _____ PREFERRED NAME: _____ DOB (DD/MM/YYYY): _____ HCN: _____ VC: _____ CURRENT ADDRESS: CITY: _____ PROV: _____ TELEPHONE #: _____ ARE WE ABLE TO LEAVE A VOICEMAIL? YES ____ NO ____ PARENT OR GUARDIAN NAME: _____	NAME: _____ TELEPHONE #: _____ FAX #: _____ OFFICE ADDRESS: PHYSICIAN: ☐ NURSE PRACTITIONER: ☐

REASON FOR REFERRAL & GOAL OF CONSULT

BRIEF DESCRIPTION:

PRIMARY DIAGNOSIS IF KNOWN: _____

PRESENTING SYMPTOMS

ANXIOUS ☐ MOOD ☐ OBSESSIONS/ COMPULSIONS ☐ CHANGES IN APPETITE ☐ FATIGUE ☐

NEGATIVE SYMPTOMS ☐ HALLUCINATIONS ☐ DELUSIONS ☐

CURRENT SAFETY RISKS:

ACTIVE SUICIDAL IDEATION ☐ PASSIVE SUICIDAL IDEATION ☐ HISTORY OF SUICIDAL THOUGHTS ☐

HISTORY OF SUICIDE ATTEMPT ☐ THOUGHTS OF HARMING OTHERS ☐ HISTORY OF VIOLENCE ☐

INTENTIONAL SELF HARM ☐ SUBSTANCE USE ☐ Please Specify: _____

PREVIOUS MENTAL HEALTH TREATMENTS

Attach psychiatric & diagnostic history including consult/progress notes, admission notes, discharge summaries etc.

Current Supports in Place:

_____

SEE ATTACHMENTS: ☐

CURRENT MEDICATIONS

_____

_____

_____

PLEASE ATTACH MEDICATION LIST OF ALL MEDICATIONS FOR THE LAST 12 MONTHS

_____ _____

SIGNATURE OF REFERRING CLINICIAN **DATE**

_____

PRINT NAME & DESIGNATION

FOR OFFICE USE ONLY:

DOES THIS REFERRAL MEET CRITERIA? _____

ATTEMPT TO CONTACT CLIENT #1 _____ #2 _____ #3 _____

APPOINTMENT DATE:

APPOINTMENT TIME:

PSYCHIATRIST:

COMPLETED BY: