Health Sciences North
Horizon Santé-Nord

Client/Patient Name:

HSN Mental Health and Addiction Treatment Program Referral Form-PART A and PART B (Info sheet)

HSN Mental Health and Addiction Treatment Program Referral - INFORMATION AND INSTRUCTIONS

If you have any questions about the referral process, please call HSN Mental Health and Addiction (705 523-4988 ex 4221)

**If your client is in need of immediate help, please direct them to 127 Cedar Street or the nearest emergency department or call 911.

Those seeking Mental Health and Addiction assessment and treatment can self-refer by **GOING DIRECTLY** TO 127 Cedar Street or **calling by 705-523-4988 ex 4221.**

Details about programs can be found: https://hsnsudbury.ca/portalen/Programs-and-Services/Mental-Health-and-Addictionsee HSN Mental

It is important to note we have found it very helpful to have **client/patient's self –refer** to treatment programs as this often results in the assessment and engagement process being much more successful.

There are ***two Parts*** to this referral Process if being completed by you:

Part A -Mental Health and Addiction Program Referral Form

Part B-Patient information sheet-**please give to client/patient as they will need this to contact us**

FAX completed HSN Referral form to: 705-523-7322

Next Steps once referral is completed by you:

1. Let your client/patient know they have **Two weeks** from our receipt of the referral request to contact us by coming directly in to 127 Cedar or by calling us at the above number to have a screen completed for services-all part of the information sheet.
2. If there is no contact within the above time frame the file will be closed to referral process
3. Remember that your client/patient can self-refer for most programs **after that TWO** week period if they have missed the referral cut-off time.
   For those with Meditech Access you can follow up with the referral outcome through this system. If you individual does not show/declines services this will be indicated in the registration EMR section. When the individual is referred to service this will also be seen within the EMR section.

For Psychiatric Outpatient Psychiatric Consultation Requests: (Separate Process)

To refer your patient for a psychiatric consultation through our Psychiatric Outpatient Clinic please ensure you **complete** the **HSN Psychiatric Consultation Request** form and fax this to **705 688-7770**

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Client/Patient Name:

HSN Mental Health and Addiction Treatment Program Referral Form-PART A and PART B (Info sheet)

PART A -Mental Health and Addiction Program Referral Form **Date of Referral** *(DD/MM/YYYY)*:_____

FAX completed HSN Referral form to: 705-523-7322

Client/Patient Information

Legal Name *(Last name, First name):*

_____

Preferred Name *(If Applicable)*:_____

Date Of Birth *(DD/MM/YYYY)*: _____ **Age**:_____

Health Card Number: _____ **VC** _____

Expiry date (DD/MM/YYYY): _____

Address_____

City: _____ **Postal Code:**_____

Telephone number(s)

Home: _____ **Cell:**_____

Other: _____

Please confirm if confidential messages can be left?

☐ Yes ☐ No

Email address (if any)_____

Can we send correspondence to this email address?

☐ Yes ☐ No *this option may be available in the future

Preferred language:

☐English ☐French ☐ Other_____

Is there a need for an interpreter (e.g., for sign language or other language)

☐ Yes ☐ No if yes, specify details: _____

ALTERNATE CONTACT

Is there an alternative contact? ☐ Yes ☐ No

Name:_____

Relationship to client/patient_____

Telephone number:_____

Gender? *(Check **ONE** only):*

☐ Female ☐ Male ☐ Other_____

☐ Prefer not to answer

Client/Patient Ethnicity: (select all that may apply)

☐ Asian ☐ Black/African ☐ Caucasian

☐ Hispanic/Latino ☐ First Nations/Metis

☐ Indian ☐ Middle Eastern

☐ Other (please indicate)_____

Referral Source Information

Name of referral source *(Last name, First name):*

_____

Check one:

☐ Family Physician ☐ Community Program

☐ Nurse Practitioner ☐ Other: _____

Address: _____

City: _____ **Postal Code:** _____

Telephone Number: _____

Fax Number:_____

Has the individual been seen by a psychiatrist previously?

☐ Yes ☐ No If yes, name of psychiatrist:

(Last name, First name):

_____

Does the individual still see a psychiatrist?

☐ Yes ☐ No If yes, name of psychiatrist:

(Last name, First name):

_____

Has the individual been involved in Mental Health and Addiction Programming in the past?

☐ Yes ☐ No If yes, what program?

(Name):_____

Is the individual still involved in program?

☐ Yes ☐ No If yes, what program?

(Name):_____

Mental Health Programs(check which service you are requesting):

☐Mood and Anxiety Program (MAP)

☐Eating Disorder Program

☐Early Psychosis Intervention Program

☐Senior's Mental Health Outreach Program

☐Case Management**(May require psychiatric referral)**

☐Perinatal Mental Health Program

Addiction Services (check which service you are requesting:

☐Outpatient Addictions

☐Outpatient Gambling services

Please include short explanation as to reason for referral._____

_____

_____

****Please give information sheet attached**