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

- ❑ Private Home/Apartment
- ❑ Setting for person with intellectual disability
- ❑ Mental Health Residence
- ❑ Correctional Facility
- ❑ Other (describe): _____
- ❑ Long-Term Care Facility/Retirement Home
- ❑ Setting for person with physical disability
- ❑ Supportive (Board and Care)
- ❑ Hospital

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 Agreeable to Referral: ❑ Yes ❑ No SDM Aware of 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: _____ (dd/mmm/yyyy) Contesting Involuntary Form ❑ Yes ❑ No
❑ 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

- ☐ Harm to Self
- ☐ Suicide
- ☐ Choking/Aspiration/Dysphagia
- ☐ Weapons
- ☐ Drug Misuse
- ☐ Harm to Others
- ☐ Sexual Aggression
- ☐ Living Alone
- ☐ Eating Disorders
- ☐ Tobacco/Nicotine Use
- ☐ Medication Non-adherence
- ☐ Wandering/Elopement
- ☐ Arson/Fire Setting
- ☐ Alcohol Misuse
- ☐ 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: _____

Client Name: _____ J # _____

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)

- ❑ Diagnostic Imaging
- ❑ Current Treatment Plan
- ❑ Nursing Summary (Progress Notes x 5 days)
- ❑ Concurrent Disorders
- ❑ BSO Summary
- ❑ Functional Assessments
- ❑ Psychological Assessments
- ❑ Psychosocial Assessment
- ❑ Wellness Recovery Action Plan (WRAP)
- ❑ 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: _____ dd/mmm/yyyy

Do you have access to videoconferencing? ❑ Yes ❑ No

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.