Capital Health

Mental Health Day Treatment Program

Referral Form

5909 Veterans Lane
Halifax, Nova Scotia B3H 3G2
Telephone (902) 473-2500
Fax: (902) 473-7126

Chart # _____

Please complete Referral Form and forward to Program Coordinator, Mental Health Day Treatment Program.

NAME: _____ DATE OF REFERRAL: _____

ADDRESS: _____

PHONE: _____ AGE: _____ DATE OF BIRTH: _____

FAMILY DOCTOR: _____ M.S.I.: _____

NAME OF UNIT REFERRING: _____

REFERRED BY: _____ PHONE: _____

_____INPATIENT _____OUTPATIENT _____PRIVATE PSYCHIATRY

Brief History and Duration of Problems: _____

_____

_____

_____

_____

Diagnostic Impression: _____

_____

Specific Treatment Goals: _____

_____

_____

_____

Living Arrangements / Will Living Arrangements change within next 3 months? _____

_____

Community Supports: _____

Source of Income: 1) Employed ( ) Where: _____

Employment Benefits: ☐ LTD ☐ STD ☐ CPP

☐ Other: name _____

2) Unemployed ( )

☐ EI ☐ Income Assistance ☐ Family Support

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History of Drug and Alcohol Abuse: _____

Currently is there Substance Abuse? Yes ☐ No ☐

Are they arranging Treatment for Addiction Issues? Yes ☐ No ☐

Relevant Medical Conditions/Physical Disabilities: _____

_____

_____

Present Medications: _____

_____

_____

Medication Coverage: Yes _____ No _____

Additional Information: (Include previous psychiatric treatment and history of violence or self harm): _____

_____

_____

Has the Patient experienced Psychosis within the last six month? Yes ☐ No ☐ Please describe: _____

_____

If transportation needs to be arranged, (i.e. funding for bus tickets), it is the responsibility of the referrer and patient to make these arrangement in advance.

Regular psychiatric follow-up by: _____

Date of appointment: _____

At the time of **Assessment Interview** the following information is required: Psychiatric Assessment, Recent Mental Status Exam and Lab Data. Please include Admission Summary and Psychological Assessment, if available.

Anticipated date of Discharge from Inpatients: (if applicable) _____

_____ _____

Signature (Legibly please) Physician or Mental Health Clinician