North Bay Regional Health Centre

Regional Mental Health Referral Form

Complete form online, print, and
fax to 705-476-6136
Phone 705-476-6240 ext. 6294
Website: www.nbrhc.on.ca

***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

Marital Status Click Dropdown Arrow to Select

Current Address _____

City _____ Province _____ Postal Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Preferred Language _____ First 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 _____ Cell _____

Relationship _____

Is this person identified as Substitute Decision Maker (SDM)? ❑ Yes ❑ No ❑ NA

Capacity to Consent

Client/SDM Agreeable to Referral ❑ Yes ❑ No Client/SDM Consents to 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

Mental Health Status

❑ Voluntary

❑ Involuntary Form # _____ Expiry Date _____ (dd/mmm/yyyy) Contesting Involuntary Form ❑ Yes ❑ No

❑ Community Treatment Order Expiry Date _____ (dd/mmm/yyyy)

Client Name: _____ NB#: _____

Criminal Legal Status

- ❑ Charges Pending (for): _____
- ❑ On Probation (for): _____
- ❑ Probationary Restrictions: _____

Substitute Decision Maker/Power of Attorney (complete only if different from Next of Kin)

Last Name: _____ First Name: _____
Address: _____ City: _____
Postal Code: _____ Phone: _____ Cell: _____
Relationship: _____

Reason for Referral

Factors Contributing to Referral (precipitating event, current symptoms, and level of urgency): Max 300 characters

Psychiatric Diagnosis(es) both known and suspected: Max 300 characters

Medical Diagnosis/Active Treatment (please include active treatment i.e., IV): Max 300 characters

Risks

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

Community Supports Prior to Admission

Have district resources been optimized? ❑ Yes ❑ No

Last Name: _____ First Name: _____
Agency Name: _____
Address: _____ City: _____
Postal Code: _____ Phone: _____ Fax: _____
Outcome of Interventions: _____

Last Name: _____ First Name: _____
Agency Name: _____
Address: _____ City: _____
Postal Code: _____ Phone: _____ Fax: _____
Outcome of Interventions: _____

Client Name: _____ NB#: _____

Preadmission Goals

Client's Goals for Admission: Max 300 characters

Family's Goals for Admission: Max 300 characters

Referent's Goals for Admission: Max 300 characters

Service Specific Documentation Required (please attach current reports)

Dual Diagnosis (Birch/Maple):

- ❑ Medication List
- ❑ Psychiatrist Notes/History
- ❑ Medical Assessments/Consultations
- ❑ DSO/Supports Intensity Scale

Psychiatric Rehabilitation (Nickel/Northern):

- ❑ Medication List
- ❑ Psychiatrist Notes/History
- ❑ Medical Assessments/Consultations

Geriatrics (Evergreen/Oak):

- ❑ Medication List
- ❑ Psychiatrist Notes/History
- ❑ Medical Assessments/Consultations
- ❑ Recent Cognitive Screening (MMSE, MoCa, etc.)
- ❑ Recent BSO PIECES Summary and Assessments (RAID, CMAI, GDS, etc.)
- ❑ Delirium workup (Labs and Urine)
- ❑ Care of the Elderly/Geriatrician/Geriatric Psychiatrist Consultation Note

Referring Physician

Full Name: _____ CPSO#: _____

Phone: _____ Fax: _____

Full Name of Primary Care Provider : _____

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 705-476-6136 or phone 705-476-6240 ext. 6294 **Website: www.nbrhc.on.ca**

Click to Save As **Click to Print, then Sign Form**

Appendix

Ensure you have completed all sections and attached all required documents. Additional information may be requested after the patient is accepted for admission, but prior to attending NBRHC.

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 **705-476-6136**. If you require additional information regarding the referral process, call 705-476-6240 ext. 6294. 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**: Provides assessment, treatment, and rehabilitation for individuals with complex and persistent mental health problems. Following discharge, consultative services are provided by a Transitional Nurse. Nickel Lodge also supports individuals experiencing substance use disorders concurrent to a serious and persistent mental health concern; specific programming is available for these individuals.
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, treatment, and rehabilitation for individuals with complex and persistent mental health problems. Following discharge, consultative services are provided by a Transitional Nurse.
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 that may be complicated by behavioural and psychological symptoms, and/or medical comorbidities.
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.