Sioux Lookout First Nations Health Authority

NODIN MHS PSYCHIATRY REFERRAL FORM

Name:	DOB (DD/MM/YYYY): Gender:
Community:	Contact #:
Health Card #:	Status Card #:
Alias/Anishinaabe Name:	Clan:
Physical Address:	
Mailing Address (☐Same as physical):	
If family/client does not have phone, OK to leave non-detailed message with:	Name:_____ Contact #:
Preferred Language:	Interpreter Required? ☐Yes ☐No Language:

NOTE: **WE CANNOT ACCEPT REFERRALS THAT REQUIRE NIHB TRAVEL WITHOUT THIS INFORMATION**

☐ Direct Psychiatry **(Pls include hx: psych, substance use, social hx, meds, & labs)**

☐ Psychiatry - Indirect Consult **(Patient not seen)** **This option allows the provider to have a consult with the psychiatrist via phone for 10-30 minutes to discuss the patient management plan, without needing the client to be seen. If you check this option off, please still ensure you are sending the above appropriate information with the referral.**

Our program is not set up to see clients in an acute/crisis state. Our psychiatrist's are pre-booked up to 3 months in advance, are not on call and do not work everyday. We do our best to fit more urgent clients in but cannot guarantee this. If a client is in crisis or acute they need to go to the nursing station or the hospital and access psychiatry on call services provided by Kenora . If we get a referral that is not appropriate for our team we connect with the referring party.

* If this is a referral for psychiatry services for ages 0-17.99 please complete the SLFNHA Paediatric Services Intake/Referral form.

Please submit the fully completed form to Nodin Mental Health Services Intake at 807-737-7532

Client's Name	Date of Birth (MM/DD/YYYY)

MANDATORY SECTION

Reason for Referral:

Please provide a brief description of the problem/concern (to assist in the referral process, if the client consents, please include Past Psychiatric History, including notes and discharge summaries from other organizations, Substance Use History, Social History, Baseline Labs and a Current list of Medications (include responses to psychotropic trials)

Referring Party Information

Name:	Date:
Agency/School:	Phone #:
Email:	Fax #:

Other Service Providers, Agencies, Physicians, Community Resources Involved? Please list as many as possible: ☐ None

Does the client/family require any assistance or accommodations in order to participate in psychiatry services? (i.e. access to a telephone, wheelchair accessibility, documents in large type or Braille, modified speed and volume of speech, specific appointment scheduling to allow for regular medical routines etc.).

☐ No

☐ Yes, please have the client/family member describe what accommodations would best assist them:

Any other information that is important or helpful regarding this referral?

Client/Parent/Guardian signature:_____ Date:_____

Alternatively: Referring Party has spoken **directly** to client/parent/guardian to discuss this referral and has received **verbal consent** to initiate this referral. → **Referring Party Initials:**

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