Primary care referral form

MENTAL HEALTH

Date: _____

Patient information *(affix label here)*

Patient name: _____

PHN: _____ DOB (dd/mm/yyyy): _____

Address: _____

City: _____ Province: _____ Postal code: _____

Phone (H): _____, (C): _____

Email: _____

Preferred contact number: _____

Is it okay for the mental health professional to leave a message identifying themselves? ☐ **Yes** ☐ **No**

If the patient is a minor, please include the following information for a parent, legal guardian, or authorized representative:

Name:	**Phone number**:
Email:	
Name:	**Phone number**:
Email:	

Referral criteria *(Patient eligible for referral if "yes" selected for any of the following questions.)*

	Yes	No	Comments
Does the patient have moderate or higher depression (a PHQ-9 score of 10 or greater)?			**PHQ-9 score**:
Does the patient have moderate or higher anxiety or agitation (a GAD-7 score of 10 or greater)?			**GAD-7 score**:
Is the patient experiencing physical or mental abuse or high emotional stress?			
Has the patient expressed desire/interest in mental health support?			

Adapted from AAFP Risk-Stratified Care Management and Coordination (2015) and Canadian Association of Emergency Physicians Applying CTAS (2012).

Does the patient know why they are being referred to our service? ☐ **Yes** ☐ **No**

What would the patient like the focus of referral to be?

- ☐ Self-management resources *(online, digital, etc.)*
- ☐ Community agency referral
- ☐ PCRP referral for mental health treatment *(only available for Enhanced/Comprehensive member physicians)*

Please note: *This portion of the form is best completed with the patient.*

Reason for referral *(please print clearly, where applicable)*

- ☐ Addiction
- ☐ Anxiety
- ☐ Attention deficit/hyperactivity (ADHD)
- ☐ COVID-19
- ☐ Cross-cultural issues
- ☐ Depression
- ☐ Eating concerns and/or weight concerns
- ☐ Emotional management/regulation
- ☐ Family/domestic violence
- ☐ Grief/loss
- ☐ Health and/or medical condition
- ☐ Life transitions
- ☐ Loneliness
- ☐ Occupation issues
- ☐ Parenting
- ☐ Personal growth
- ☐ Psychiatric disorder: _____
- ☐ Relationships
- ☐ Sexuality
- ☐ Stress
- ☐ Trauma
- ☐ Other: _____

Additional information

Please note: If the patient is in severe distress or is an imminent harm to themselves or others, refer to **Distress Centre Calgary (403.266.4357)**, the **Mental Health Help Line (1.877.303.2642)**, or contact emergency services.

Please attach any other relevant information or documents such as the Mental Health Intake Form, Wellbeing Screen, GAD-7, PHQ-9, etc.

Referring physician name *(please print clearly)*: _____

Referring healthcare provider name *(if applicable)*: _____

Family physician name *(if different)*: _____

Clinic name: _____

Phone number: _____

Fax number: _____

Please **fax** completed form to **855.966.4102**.