CAMPBELLFORD
MEMORIAL HOSPITAL
CAMPBELLFORD & DISTRICT COMMUNITY MENTAL HEALTH CENTRE

146 Oliver Road
Campbellford, ON K0L 1L0
Phone (705) 632-2015
Fax (705) 653-0436
e-mail: wellness@cmh.ca

REFERRAL FORM

If you have questions about the referral process please call 705-632-2015 x 0

INFORMATION FOR REFERRING PROVIDERS:

- If the individual is in **crisis, please call 911** or send them to the nearest Emergency Department.
- A physician or nurse practitioner referral is required for a psychiatric assessment. **Please complete Pages 2-6**
- To help us provide the best care possible include **relevant documents**, such as previous psychiatric consultations, discharge summaries, medication records, psychological reports, medical reports, and physical findings.
- **For Addiction Services**, Individuals may self-refer by calling FOURCAST at 705-653-3352

INFORMATION FOR YOUR PATIENT:

- Please ensure the individual is aware that the referral is being made.
- Our program will make **two** attempts to contact the client and if not successful a letter will be mailed to them. If they do not respond within 10 business days of the letter being sent, the file will be closed and the referring source will be notified.

HOW TO SUBMIT A REFERRAL TO OUR PROGRAM:

- **Please fax the completed Referral form to 705-653-0436**
- Please ensure the referral is fully completed. Any referral that is not competed in full will be returned to the referral source.
- If the individual meets the criteria of **moderate to severe mental illness**. Complete the enclosed referral form (Pages 2-6) **AND** the **GAD7** (scoring 10-21) AND **PHQ-9** (scoring 10-27) scale and fax to the above number.

If the individual **does not** meet the criteria of moderate to severe mental illness – see the enclosed list of resources (Page 7), and refer as appropriate.

We are happy to accept this referral if **ALL** the information is included. Any Referrals not fully completed will be returned.

Patient Information

Name
First Name: Last Name:

Preferred Name: (If Applicable)

Patient Address:

Address: _____

City: _____ Province: _____ Postal Code:_____

Date of Birth (DD/MM/YYYY):

Gender:

Health Card Information:

Heath Card #_____ Version Code: _____ Expiration Date (DD/MM/YYYY)_____

Best Phone number to contact client:_____ ☐ **Home** ☐ **Cell** ☐ **Work** ☐ **Other**

Alternate phone number to contact client:_____ ☐ **Home** ☐ **Cell** ☐ **Work** ☐ **Other** _____

Client consents to voicemail messages ☐ **Yes** ☐ **No**

If this is a cell phone number can a text message be sent to this client? ☐ **Yes** ☐ **No**

Service(s) Requested (Please indicate which of the following programs you would like to refer your client for.)

Programs	Description of the program	Requirements
☐ **Counselling & Treatment**	4-6 sessions to discuss emotional issues and coping strategies with goal setting & access to groups.	☐ PHQ-9 Depression Scale (attached) ☐ GAD 7 (attached)
What does this client hope to accomplish in counselling?		
☐ **Case Management**	To stabilize and achieve goals to improve quality of life, advocacy, and service coordination	
☐ **Early Psychosis Invention Lynx Program**	Offers assessment, treatment support and education, specifically for people ages 14-35 who are experiencing the early stages of psychosis	
☐ **Court Support**	Assistance to Individuals with Mental Health difficulties who have criminal charges within Northumberland County.	Clients; next court date Date:_____ ☐ Cobourg Court ☐Brighton Court ☐Charges were laid in Northumberland
☐ **Psychiatric Consultation**	Psychiatry consultation for diagnostic clarification, treatment recommendations and medication review.	☐ Doctor or Nurse Practitioner to complete referral ☐ Urgent ☐ Elective

Reason for Referral/Contributing Factors

☐ Problem/Substance use	☐ Self-harm	☐ Symptoms of psychosis (delusions/hallucinations)
☐ History of Trauma/Abuse	☐ Sleep disturbance	☐ Inability to care for self-due to mental illness
☐ Symptoms of anxiety	☐ Chronic pain	☐ Mood related symptoms ☐ Elevated ☐ Depressed
☐ Irritability	☐ Aggression	

Mental Illness Diagnosis: _____ ☐ Confirmed ☐ Suspected

Risk and Safety Concerns:

	Yes/No	Comments (If you answered Yes please explain)
Suicide Attempts/Ideation	☐ Yes ☐ No	
Aggressive Behaviour	☐ Yes ☐ No	
Current Criminal Charges	☐ Yes ☐ No	

Current Medication(s)

Medication	Dosage	Compliance (taking medications as prescribed)
		☐ Yes ☐ No ☐ Unknown
		☐ Yes ☐ No ☐ Unknown
		☐ Yes ☐ No ☐ Unknown
		☐ Yes ☐ No ☐ Unknown
		☐ Yes ☐ No ☐ Unknown

Additional Information:

Referring Source Information

Name First Name: Last Name:	Billing Number:
Phone Number: _____	Fax Number: _____

Family Physician Information (if different from above)

Name First Name: Last Name:	
Phone Number: _____	Fax Number: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

A2662B 10-04-2005

General Anxiety Disorder (GAD-7)

NAME DATE

1. Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
• Feeling nervous, anxious, or on edge	☐ 0	☐ 1	☐ 2	☐ 3
• Not being able to stop or control worrying	☐ 0	☐ 1	☐ 2	☐ 3
• Worrying too much about different things	☐ 0	☐ 1	☐ 2	☐ 3
• Trouble relaxing	☐ 0	☐ 1	☐ 2	☐ 3
• Being so restless that it's hard to sit still	☐ 0	☐ 1	☐ 2	☐ 3
• Becoming easily annoyed or Irritable	☐ 0	☐ 1	☐ 2	☐ 3
• Feeling afraid as if something awful might happen	☐ 0	☐ 1	☐ 2	☐ 3
Add the score for each column				
TOTAL SCORE *(add your column scores)*				
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	☐ 0	☐ 1	☐ 2	☐ 3

Scoring *Add the results for question number one through seven to get a total score.*

If you score 10 or above you might want to consider one or more of the following:

1. Discuss your symptoms with your doctor,
2. Contact a local mental health care provider or
3. Contact my office for further assessment and possible treatment.

Although these questions serve as a useful guide, only an appropriate licensed health professional can make the diagnosis of Generalized Anxiety Disorder.

A score of 10 or higher means significant anxiety is present. Score over 15 are severe.

GUIDE FOR INTERPRETING GAD-7 SCORES

Scale	Severity
0-9	None to mild
10-14	Moderate
15-21	Severe

GAD-7 developed by Dr. Robert L. Spitzer, Dr. K. Kroenke. et.al.

CAMPBELLFORD MEMORIAL HOSPITAL

146 Oliver Road
Campbellford, ON K0L 1L0
Phone (705) 632-2015
Fax (705) 653-0436
e-mail: wellness@cmh.ca

Resources

Northumberland County

Campbellford & District Community Mental Health Centre – outpatient counselling, case management, and crisis support for **moderate to severe mental illness**. Specialized programs include: Early Psychosis Intervention and Criminal Court Support/Diversion 705-632-2015/1-877-632-2015

Four County Crisis Program – a 24-hour telephone crisis response program 866-995-9933

Four County Addiction Services Team Inc. (4CAST) – counselling for individuals who are struggling with use of alcohol, drugs, or problem gambling 800-461-1909 www.fourcast.ca

The Trent Hills Family Health Team – For patients of the Trent Hills Family Health Team only. Group programs that teach coping skills to gain insight/understanding. To start the intake process call 705-653-1801 ext. 4918.

Northumberland Community Counselling Centre – counselling for individuals struggling with personal issues related to grief, caregiving, family or marital conflict, trauma, or other life stressors 866-748-5720 www.northumberlandccc.com

Cornerstone Family Violence Prevention Centre – support for individuals who are victims of family/domestic violence 800-263-3757 www.cornerstonenorthumberland.ca

***Community Care Northumberland* Hospice Services** – individual and group palliative, grief and bereavement support 855-473-8875 www.commcare.ca

Northumberland Hills Hospital Walk-in Counselling Clinic- For Children, youth and adults (Aged 7 & up). 1011 Elgin St. W. Suite 200 Cobourg, 905-377-9891. Tuesdays 8am-4pm & Thursdays 11am-6pm. www.mentalhealthwalkinclinc.ca

Peterborough County

Campbellford & District Community Mental Health Centre – outpatient counselling, case management, and crisis support for **moderate to severe mental illness**. Specialized programs include: Early Psychosis Intervention and Criminal Court Support/Diversion 705-632-2015/1-877-632-2015

Four County Crisis Program – a 24-hour telephone crisis response program 866-995-9933

Canadian Mental Health Association-Halliburton, Kawartha, Pine Ridge - Education, advocacy, therapeutic supports and assistance with social determinants, to improve mental health recovery and quality of life 705-748-6711 or 1-866-990-9956

Four County Addiction Services Team Inc. (4CAST) – counselling for individuals who are struggling with use of alcohol, drugs, or problem gambling 800-461-1909 www.fourcast.ca

The Trent Hills Family Health Team – For patients of the Trent Hills Family Health Team only. Group programs that teach coping skills to gain insight/understanding. To start the intake process call 705-653-1801 ext. 4918.

Northumberland Hills Hospital Walk-in Counselling Clinic- For Children, youth and adults (Aged 7 & up). 1011 Elgin St. W. Suite 200 Cobourg, 905-377-9891. Tuesdays 8am-4pm & Thursdays 11am-6pm. www.mentalhealthwalkinclinc.ca

Hastings & Prince Edward County

Open Line, Open Mind – crisis support and a free, confidential service to get information and support for all mental health and addictions in Hastings County 613-310-6736

Addiction & Mental Health Services, Hastings/Prince Edward crisis support and a free, confidential service to get information and support for all mental health and addictions in Hastings County. CENTRAL INTAKE: 613-967-4734/CRISIS: 613-969-7400 ext. 2753

The Trent Hills Family Health Team – For patients of the Trent Hills Family Health Team only. Group programs that teach coping skills to gain insight/understanding. To start the intake process call 705-653-1801 ext. 4918.

Northumberland Hills Hospital Walk-in Counselling Clinic- For Children, youth and adults (Aged 7 & up). 1011 Elgin St. W. Suite 200 Cobourg, 905-377-9891. Tuesdays 8am-4pm & Thursdays 11am-6pm. www.mentalhealthwalkinclinc.ca

Province Wide:

Big White Wall - an online mental health and wellbeing service offering self-help programs, creative outlets and a community that cares. www.bigwhitewall.ca/

Bounce Back - Reclaim your health, is a free skill-building program designed to help adults and youth 15+ manage symptoms of depression and anxiety (physician referral needed) https://bouncebackontario.ca/ Toll-Free: 1•866•345•0224

Connex Ontario –Information about Addiction, Mental Health, and Problem Gambling Treatment Services 1-866-531-2600 https://www.connexontario.ca/

211 Ontario - 211 is a helpline for community and social service information in Ontario, Canada. Free | 24/7 | 150+ languages (CALL 2-1-1) https://211ontario.ca/