Covenant Health Misericordia

Outpatient Mental Health

General Group Referral Form

Tel 780-735-2792 Fax 780-735-2549

Attach Patient Label or please provide:

Patient Name: _____

DOB: _____

PHN: _____

Patient Telephone Number: _____

May a detailed voicemail be left?: ☐ Yes ☐ No

Referring Provider (Physician/Mental Health Provider):	Date of Referral:
Provider Phone:	Provider Fax:

TO AVOID DELAY, REFERRALS MUST INCLUDE THE FOLLOWING INFORMATION.

INCOMPLETE REFERRALS WILL BE RETURNED.

Is client aware of referral? ☐Yes ☐No

Does client have access to Zoom? ☐Yes ☐No

Client is 18 years of age or over? ☐Yes ☐No

CLIENT MUST HAVE AT LEAST ONE OF THE FOLLOWING PROVIDERS:

- Mental Health Therapist Name: _____ Tel._____
- Psychiatrist Name: _____ Tel._____
- Family Doctor Name: _____ Tel._____

At time of referral:

- Is client an inpatient? ☐Yes ☐No Expected date of discharge: _____
- Is client attending Day Hospital? ☐Yes ☐No Expected date of discharge: _____

Please include a PRINTED COPY of full psychiatric history (within last 3 months).

Current DSM-5 Diagnosis:	**LOCUS SCORE*** (if available):
Medical Concerns:	
Psychosocial Stressors:	
Please expand on any particular concerns: *HISTORY OF AGGRESSION AND/OR KNOWN TRIGGERS*	
Current and/or Previous Programs/Therapy:	

Date Received: _____ Referral #: _____

Please note that OPMH is a LOCUS 1 to 3 level program.