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:
Address/Clinic:	
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: ____________________

DOES PROVIDER HAVE ACCESS TO CONNECT CARE? ☐ **Yes** ☐ **No**
If NO, please include a PRINTED COPY of full psychiatric history (within last 3 months).

Current DSM-5 Diagnosis:	**LOCUS SCORE*** (if available):
Medical Concerns:	

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

Updated December 2024

Psychosocial Stressors:

Recent Medication Changes:

Please expand on any particular concerns: *HISTORY OF AGGRESSION AND/OR KNOWN TRIGGERS*

Current and/or Previous Programs/Therapy:

Date Received: ____ Referral #: _____________________________________

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