

Information for Referring Providers

Catchment Area:

- one-Link is the coordinated access service for funded addictions and mental health service providers in Mississauga and Halton. For services outside of this area, please contact Connex Ontario for the most appropriate resources.

www.connexontario.ca

Referral Process:

- Submitted referrals are reviewed by one-Link and either forwarded directly to the appropriate service, or a telephone screening is scheduled with the patient to gather more information and determine the next step. If a screening is required, we will email the patient and/or leave two voice mail messages; the number will appear as Halton Healthcare. Patients are welcome to contact us directly at **905-845-2571, ext. 5160** or Toll free at **1-844-216-7411** to discuss their referral at any time.

PsychCHAT

5-10 minute chat with a psychiatrist to obtain general recommendations for addictions and mental health needs.

You can submit a PsychCHAT request at www.one-Link.ca (DO NOT USE THIS REFERRAL FORM)

- Available to primary care providers practicing in Oakville, Milton, Georgetown, Acton, and Mississauga
- Your request will be responded to within three business days



PsychCHAT

Adult Services

Psychiatric Consultation: One-time psychiatric consultation is available with the understanding that the referring physician is responsible for the implementation of recommendations.

Inclusion Criteria: For conditions related to depressive and anxiety disorders, there must be evidence of two medication trials within the current episode of illness.

Exclusion criteria: Patients seeking long-term psychiatric follow-up, psychiatric consultation for court/legal, custody, disability, or insurance purposes, or a second opinion not being requested by the current treating psychiatrist.

Access to Specialized Adult Services: one-Link does not have access to services for the assessment or treatment of Adult Attention Deficit Disorder (ADD/ADHD), or developmental disability. An information package including appropriate resources will be sent back in response to receipt of referrals requesting these services.

Child & Adolescent Services

- The role of one-Link is to determine if initial eligibility criteria are met for hospital or community based child and adolescent mental health services. Referrals will be processed accordingly.
- Any requests for psychiatric consultation that do not contain all of the required information will not be processed until such information is received.

Crisis Services

one-Link refers to non-urgent services only. For patients experiencing a mental health or addiction emergency, consider issuing a Form 1 or direct them to their nearest hospital emergency department. The following services are also available for patients to contact 24 hours a day, 7 days a week:

Halton

- Halton Crisis Outreach and Support Team (COAST): 1-877-825-9011
- Reach Out Centre for Kids (up to age 17): 905-878-9785

Peel / Etobicoke

- 24.7 Crisis Support Peel (all ages): 905-278-9036
- Gerstein Crisis Centre (south Etobicoke): 416-929-5200

SECTION A: REFERRING PROVIDER INFORMATION		<input type="checkbox"/> I am referring myself for services	
Name: _____		<input type="checkbox"/> MD <input type="checkbox"/> NP <input type="checkbox"/> Other: _____	
Billing #:	Address:		
Signature:	Phone:		
Referral Date:	Fax:		
Family Physician Name:		Phone:	
SECTION B: PATIENT INFORMATION			
Last Name:	First Name:	Preferred Name:	
OHIP #:	Version Code:	Date of Birth: (DD/MM/YYYY)	
Gender:	Pronouns:		
Address:	City:	Prov.	Postal Code:
<i>The referral source confirms that the patient consents for one-Link to call/email them regarding this referral & appointment booking.</i>			
Phone:		Email:	
SECTION C: CONSIDERATIONS			
Preferred language:		Is an interpreter requested? <input type="checkbox"/> No <input type="checkbox"/> Yes	
<input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Hearing Impairment <input type="checkbox"/> Sight Impairment <input type="checkbox"/> Age 65+ Housebound <input type="checkbox"/> Falls <input type="checkbox"/> Wandering <input type="checkbox"/> Pregnant or has given birth within the past 12 months			
GO DIRECTLY TO <u>SECTION G FOR EATING DISORDERS</u> OR <u>SECTION H FOR CHILD & ADOLESCENT MENTAL HEALTH</u>			
SECTION D: ADULT SERVICES REQUESTED - PLEASE CHECK ALL THAT APPLY			
Does your patient currently have a psychiatrist? <input type="checkbox"/> No <input type="checkbox"/> Yes – <i>if yes, please provide name, and attach consult note</i>			
Name: _____			
<input type="checkbox"/> Psychiatric Consultation - <input type="checkbox"/> Diagnostic Clarification <input type="checkbox"/> Treatment Recommendations <input type="checkbox"/> Other: _____ <input type="checkbox"/> If patient seen by Psychiatry within the last year, evidence of implementation of recommendations attached			
<input type="checkbox"/> Mental Health Treatment		<input type="checkbox"/> Employment Supports	
<input type="checkbox"/> Early Psychosis Intervention		<input type="checkbox"/> Substance Use Treatment	
<input type="checkbox"/> Other: _____			
Why are you referring this patient now?			<input type="checkbox"/> Relevant clinical and medical history attached
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Obsessive Compulsive Disorder
		<input type="checkbox"/> Post-Traumatic Stress Disorder	
<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Delusions	<input type="checkbox"/> Disorganized Thinking or Speech	
<input type="checkbox"/> Substance Use Health Concerns		<input type="checkbox"/> Substance Withdrawal Symptoms	
SECTION E: RISK & SAFETY			
<input type="checkbox"/> Violence / Risk to others		<input type="checkbox"/> Self-Harm	<input type="checkbox"/> Active Suicidal Thoughts
		<input type="checkbox"/> Recent Suicide attempt	
Details: _____			
<i>(ONE-LINK REFERS TO NON-URGENT SERVICES ONLY. FOR CLIENTS EXPERIENCING A MENTAL HEALTH OR ADDICTION CRISIS DIRECT THEM TO CRISIS RESOURCES OR THE NEAREST HOSPITAL EMERGENCY DEPARTMENT)</i>			
SECTION F: MEDICATIONS – LIST OR ATTACH			
Current Medications (Name / Dose / Frequency)		Past Psychiatric Medications (Name / Dose / Frequency)	
Total duration of all antipsychotic medication trials: <input type="checkbox"/> 6 months or more <input type="checkbox"/> less than 6 months			

Patient Name: _____ Date of Birth (DD/MM/YYYY): _____

SECTION G: EATING DISORDER – Only Complete If You Are Referring for Eating Disorders Services

Has this patient previously received eating disorders treatment? No Yes

If so please specify: _____

Date: _____ Location: _____

Current Weight: _____ lbs kg Current Height: _____ cm inches BMI: _____
 Heart Rate: _____ Blood Pressure: _____ Date of reading: _____

Lowest Weight: _____ lbs kg Date: _____ Date of last menstrual
 Highest Weight: _____ lbs kg Date: _____ period: _____

For patients 18yrs and under attach a growth chart if available no growth chart available

Weight Control Methods

Please indicate all that apply	Frequency	Duration
Food intake restrictions		
Binge Eating		
Induced vomiting		
Laxative use		
Exercise Quantity (per week)		
Chewing and Spitting		
Diet Pills		
Substance Use		
Other		

ECG (completed within the last 30 days) ****MANDATORY****

Lab results **MANDATORY – results must be completed within the last 30 days

- | | |
|---|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> CBC and differential <input type="checkbox"/> Urea <input type="checkbox"/> Creatinine <input type="checkbox"/> Sodium (Na+) <input type="checkbox"/> Potassium (K) <input type="checkbox"/> Glucose <input type="checkbox"/> Calcium (Ca2+) <input type="checkbox"/> Magnesium <input type="checkbox"/> Phosphate | <ul style="list-style-type: none"> <input type="checkbox"/> Amylase <input type="checkbox"/> Folate <input type="checkbox"/> RBC <input type="checkbox"/> TSH <input type="checkbox"/> ALT, ALP (Alkaline Phosphatase) <input type="checkbox"/> Bilirubin <input type="checkbox"/> GGT <input type="checkbox"/> Albumin <input type="checkbox"/> Ferritin <input type="checkbox"/> Vitamin B12 |
|---|--|

Patient Name: _____ Date of Birth (DD/MM/YYYY): _____

SECTION H: CHILD & ADOLESCENT MENTAL HEALTH

- Most recent consult note attached.
- If patient seen by psychiatry within the last year, evidence of implementation of recommendations attached.

Reason for Referral:

- Counselling
- Behavioural Supports
- Autism Supports (for patients already diagnosed)
- Adjustment Issues
- Other: _____

- Psychiatric Consultation – Diagnostic Clarification
- Psychiatric Consultation – Medication Recommendations

What is the specific advice you are seeking from the psychiatrist? _____

By submitting this referral, the requester verifies having directly assessed the patient and that the patient/family is agreeable to a referral requesting psychiatric consultation.

For patients under age 12 - Who is the primary decision maker or person responsible for the child?
Guardian Name: _____ Phone _____

For patients age 12 and over – Service providers may contact the patient directly to offer services and obtain their consent for a referral. How does the patient prefer to be contacted?
 Contact patient directly at phone / email: _____
 Patient authorizes contact with caregiver at phone: _____

For Patients Under Age 6:
We recommend that you refer the child and their family to the nearest EarlyON Centre, as they provide services for the 0-6 age range. More information and a search tool for the nearest Centre can be found here:
<https://www.ontario.ca/page/find-earlyon-child-and-family-centre>