Referral Form: Fax to 905-338-2878
Inquiries: 1-844-216-7411   www.one-Link.ca

one-Link
Connecting you to addictions and mental health services

Halton Healthcare
GEORGETOWN • MILTON • OAKVILLE

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

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	Peel / Etobicoke
• Halton Crisis Outreach and Support Team (COAST): 1-877-825-9011 • Reach Out Centre for Kids (up to age 17): 905-878-9785	• 24.7 Crisis Support Peel (all ages): 905-278-9036 • Gerstein Crisis Centre (south Etobicoke): 416-929-5200

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SECTION A: REFERRING PROVIDER INFORMATION	☐ **I am referring myself for services**
Name:	☐ MD ☐NP ☐ 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:

The referral source confirms that the patient consents for one-Link to call/email them regarding this referral & appointment booking.

Phone: Email:

SECTION C: CONSIDERATIONS

Preferred language: Is an interpreter requested? ☐No ☐Yes

☐Cognitive Impairment ☐Hearing Impairment ☐Sight Impairment ☐Age 65+ Housebound
☐Falls ☐Wandering ☐Pregnant or has given birth within the past 12 months
☐Unsheltered / unhoused or at risk ☐Unattached to primary care / Barriers to connecting with primary care

GO DIRECTLY TO SECTION G FOR EATING DISORDERS OR SECTION H FOR CHILD & ADOLESCENT MENTAL HEALTH

SECTION D: ADULT SERVICES REQUESTED - PLEASE CHECK ALL THAT APPLY

Does your patient currently have a psychiatrist? ☐ No ☐ Yes – *if yes, please provide name, and attach consult note*
Name:

☐ Psychiatric Consultation - ☐ Diagnostic Clarification ☐ Treatment Recommendations ☐ Other:__________________
☐ If patient seen by Psychiatry within the last year, evidence of implementation of recommendations attached

☐ Mental Health Treatment	☐ Employment Supports
☐ Early Psychosis Intervention	☐ Substance Use Treatment
☐ Other:	

Why are you referring this patient now? ☐ ***Relevant clinical and medical history attached***

☐ Anxiety	☐ Depression	☐ Bipolar Disorder	☐Obsessive Compulsive Disorder	☐ Post-Traumatic Stress Disorder
☐ Hallucinations	☐ Delusions	☐Disorganized Thinking or Speech		
☐Substance Use Health Concerns			☐Substance Withdrawal Symptoms	

SECTION E: RISK & SAFETY

☐ Violence / Risk to others	☐ Self-Harm	☐ Active Suicidal Thoughts	☐ Recent Suicide attempt

Details:____

(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)

SECTION F: MEDICATIONS – LIST OR ATTACH

Current Medications (Name / Dose / Frequency)	**Past Psychiatric Medications (Name / Dose / Frequency)**

Total duration of all antipsychotic medication trials: ☐ 6 months or more ☐ less than 6 months

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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 period:_____________
Highest Weight:________ ☐ lbs ☐ kg Date:____________

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

☐ CBC and differential
☐ Urea
☐ Creatinine
☐ Sodium (Na+)
☐ Potassium (K)
☐ Glucose
☐ Calcium (Ca2+)
☐ Magnesium
☐ Phosphate
☐ Amylase
☐ Folate
☐ RBC
☐ TSH
☐ ALT, ALP (Alkaline Phosphatase)
☐ Bilirubin
☐ GGT
☐ Albumin
☐ Ferritin
☐ Vitamin B12

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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