

MHA PCA Standardized Referral Form (Paper-Based)

* Indicates a required field

Information for Referring Providers

Mental Health and Addictions Provincial Coordinated Access (MHA PCA)

- MHA PCA is a provincial initiative to streamline access to services and is led by the Mental Health and Addictions Centre of Excellence (MHA CoE) within Ontario Health (OH).
- MHA PCA is an integrated system that utilizes standardized tools and processes to coordinate equitable and seamless access to appropriate mental health and addiction services and supports for people across their lifespan.
- All funded community and hospital outpatient MHA Services (core services) are in scope.

MHA Coordinated Access Hub

- Referrals for mental health and addictions (MHA) services will be sent to MHA Coordinated Access Hubs who will receive, review, and distribute referrals based on standardized, predetermined workflows and client preferences. The clinical function of MHA PCA is triage, screening and service matching using standardized clinical tools and resources to determine the type, priority and level of care need of individuals and connect them to the most appropriate MHA services and supports.
- All community and hospital outpatient MHA services (core services) funded by Ontario Health can be accessed through MHA Coordinated Access Hubs.
- General information and support on available services and referral status will be provided by MHA Coordinated Access hubs for patients, families, and referring providers.

Referral Process - *** Only completed referrals will be accepted and processed***

- Referring provider submits referral
- Referral reviewed by MHA Coordinated Access Hub for completeness and care need
 - All referrals triaged by clinicians
 - Some referrals may require a screening interview with patient/client to determine care need
- Referral sent to most appropriate service based on care need
- Patient/client contacted for care assessment and care plan.

Child & Youth Mental Health

- MHA PCA Hubs will work with Child and youth MHA service providers and establish linkages to manage child and youth mental health referrals.

How to Refer to MHA PCA

- Fax the completed MHA PCA referral form to 905-338-2878
- Please attach all **relevant:**
 - Consult reports or discharge summaries
 - Laboratory and diagnostic investigations
 - Assessments or patient-reported scales (e.g. PHQ-9, GAD-7)

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*Section A: Patient Information					
Surname:		Mobile #:		Can leave voicemail <input type="checkbox"/> yes <input type="checkbox"/> no	
First:		Home #:			
DOB (yyyy-mm-dd):		Business #:			
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other:		Email:			
HN (ON-555555132-VC):		Best contact method: <input type="checkbox"/> Mobile <input type="checkbox"/> Home <input type="checkbox"/> Business <input type="checkbox"/> Email			
Address:					
Street Address		Line 2		City/Town	Province
Section B: Additional Patient Information					
Sex assigned at birth: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Intersex <input type="checkbox"/> Unknown					
Pronouns: <input type="checkbox"/> She/Her <input type="checkbox"/> He/Him <input type="checkbox"/> They/Them <input type="checkbox"/> Other:					
Preferred name:					
Preferred language: <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other (<i>please specify</i>): <input type="checkbox"/> Interpreter required					
<input type="checkbox"/> Alternate contact		Contact name:*		Relationship:	
Alternate Contact Phone #:					
Is Alternate Contact the appointment booking contact? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Unsafe contact persons (do not speak with):			
<input type="checkbox"/> Only speak with patient directly					
Accessibility Concerns or Disability					
<input type="checkbox"/> Falls Risk		<input type="checkbox"/> Mobility		<input type="checkbox"/> Hearing	
				<input type="checkbox"/> Vision	
<input type="checkbox"/> Other					
Details of special considerations:					
Section C: Additional Referral Information					
<input type="checkbox"/> Currently followed by a psychiatrist (within past 6 months)		Psychiatrist name:*			
		Psychiatrist Phone Number:			
<input type="checkbox"/> Currently receiving support/treatment from any MHA organization/programs/provider		<i>Please describe:</i>			
Triage Considerations					
Requested Priority:* <input type="checkbox"/> Routine <input type="checkbox"/> Urgent (if urgent, provide reason):					
<input type="checkbox"/> Referral for child or youth (<18 years)		<i>Custody Status (e.g. parents together, shared, sole, informal arrangements): *</i>			
<input type="checkbox"/> Children's Aid Society Involved					
<input type="checkbox"/> Currently pregnant or <12 months post-partum		<i>Please describe (e.g. estimated delivery date, birth date, birth site):*</i>			
<input type="checkbox"/> Recent Hospitalization or ER Visit for this issue		<i>Please describe (e.g. date, reason for hospitalization):</i>			
Concern(s) / Indication(s) Triggering Referral*					
<input type="checkbox"/> Anxiety or Panic Symptoms		<input type="checkbox"/> Emotional Dysregulation (e.g., anger, aggression, mood swings)			
<input type="checkbox"/> Bipolar / Mania Symptoms		<input type="checkbox"/> Depressive Symptoms or Low Mood			
<input type="checkbox"/> Obsessions or Compulsions		<input type="checkbox"/> Difficulty coping with life stressors (e.g. grief, loss)			
<input type="checkbox"/> Behavioural Addictions (e.g., gambling, internet use, gaming, sexual)		<input type="checkbox"/> Psychotic Symptoms (e.g., hallucinations, delusions, etc.)			
		<input type="checkbox"/> First Episode of Psychosis			
<input type="checkbox"/> Trauma-Related Symptoms / PTSD (e.g., hypervigilance, flashbacks)		<input type="checkbox"/> Personality-Related Concerns (e.g., unstable relationships, chronic conflict with others)			
<input type="checkbox"/> Dementia-Related Behaviours		<input type="checkbox"/> Substance Use Concerns (<i>specify</i>):			
<input type="checkbox"/> Eating Concerns (restricted or binge eating)		* Complete Section G if selected			
<input type="checkbox"/> Other (<i>please specify</i>):					

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Reason for Referral:*					
<i>Clinical Question / Goal(s) of Referral with Relevant History, Management and Investigations*</i>					
[Optional] Service(s) Requested					
Please Note: Coordinated Access will match the patient to services using the referral details and, where applicable, contacting the patient for any additional information to identify the most appropriate service to meet their care need. The final service match or recommendation may differ from the service selected.					
<input type="checkbox"/> Counselling / Psychotherapy Services		<input type="checkbox"/> Case Management		<input type="checkbox"/> Supportive Housing	
<input type="checkbox"/> Stabilization on Opioid Agonist Therapy		<input type="checkbox"/> Peer Support Services		<input type="checkbox"/> Family Support Services	
<input type="checkbox"/> Substance Use / Addiction Treatment		<input type="checkbox"/> Withdrawal Management		<input type="checkbox"/> Court Support	
<input type="checkbox"/> Bed-based Addiction Services (formerly known as Residential Addictions Services)					
<input type="checkbox"/> Psychiatry Consultation (<i>select all that apply</i>):					
<input type="checkbox"/> Diagnostic Clarification		<input type="checkbox"/> Medication/Treatment Recommendations		<input type="checkbox"/> rTMS <input type="checkbox"/> ECT	
<input type="checkbox"/> Other Services (<i>please specify</i>):					
Section D: Current Risks					
<input type="checkbox"/> Possible Safety Concern to Others (e.g. aggression, homicidal threats or ideation)			<input type="checkbox"/> Legal Involvement / Court Orders (e.g. current charges, probation, parole, CTO/ORB conditions)		
<input type="checkbox"/> Suicidal Ideation or Attempt		<input type="checkbox"/> Self-Harm Behaviours		<input type="checkbox"/> Housing Instability	
<input type="checkbox"/> Other					
<i>If selected, please describe*:</i>					
Section E: Medical/Mental Health History					
<input type="checkbox"/> CPP attached <i>Please delete any sensitive information you do not intend to share from the CPP</i>					
Past Medical/Mental Health History <input type="checkbox"/> <i>Relevant medical history /notes attached</i>					
Current Medications (<i>name, dose, frequency</i>) <input type="checkbox"/> List attached					
Section F: Referring Provider Information					
Name:		Role: <input type="checkbox"/> Primary Care Provider (PCP) <input type="checkbox"/> Other:			
Phone:		Fax:		Billing #:	
Address:					
Street Address		Line 2		City/Town	Province
				Postal Code	
PCP Name:		<input type="checkbox"/> PCP same as referring provider		<input type="checkbox"/> Patient does <u>NOT</u> have a PCP	
Signature:			Date:		

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Section G: Additional Eating Disorders Questions <i>(only complete if "Eating Disorders" selected above)</i>	
Previously received eating disorders treatment <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify program name and date):*	
Current Weight (kgs):*	Current Height (cm):*
BMI:	Lowest Weight (kgs):
Heart Rate:*	Date of Reading (HR/BP):*
Date of LMP:	
Weight Control Methods *	
	<i>(Please describe (e.g., frequency, duration):</i>
<input type="checkbox"/> Food Intake Restrictions	
<input type="checkbox"/> Binge Eating	
<input type="checkbox"/> Induced Vomiting	
<input type="checkbox"/> Laxative Use	
<input type="checkbox"/> Exercise Quantity (per week)	
<input type="checkbox"/> Chewing and Spitting	
<input type="checkbox"/> Diet Pills	
<input type="checkbox"/> Other	
Please attach the following*:	
<ul style="list-style-type: none"> Growth chart for ≤18 years old, if available ECG (within last 30 days) Full lab results (within the last 30 days): CBC and Differential, Urea, Creatinine, Sodium, Potassium, Glucose, Calcium, Magnesium, Phosphate, Amylase, Folate, RBC, TSH, ALT, ALP, Bilirubin, GGT, Albumin, Ferritin, Vitamin B12 	