Waypoint
CENTRE for MENTAL HEALTH CARE
CENTRE de SOINS de SANTÉ MENTALE

500 Church Street, Penetanguishene ON L9M 1G3
500, rue Church, Penetanguishene (Ontario) L9M 1G3
705-549-3181 www.waypointcentre.ca

Waypoint Centre for Mental Health Care Referral

☐ **Inpatient Services** ☐ **Outpatient / Consultation**

If you have any questions about the referral process, please call Waypoint Centre for Mental Health Care Central Intake at **705-549-3181, ext. 2308**.

Based on the information provided on the referral, the Waypoint Central Intake team will match the patient needs to services.

Visit our website for a list of services, programs and criteria.

Referral Requirements – a referral cannot be processed without the following:

1. **Physician / Nurse Practitioner** – referral is required for all Waypoint Inpatient services
2. **Psychiatric diagnosis** – the patient must have a psychiatric diagnosis
3. **Medications** – a current list of medications
4. **Risk Identification** – at the time of the referral the patient risks are documented
5. **Labs and Diagnostics** – recent and relevant lab work as well as diagnostic reports
6. **Consultations** – psychiatric and other relevant consultations and discharge summaries
7. **Medical / Problem Diagnosis** – list of medical diagnosis / problems

Do not use this referral form for **Forensic Services.** For Regional and Provincial Forensic referrals contact 705-549-3181, ext. 2665.

Please send the completed Referral Form and all supporting documents to Waypoint Central Intake by Fax to 705-549-1812 or by email to centralintake@waypointcentre.ca.

We cannot begin processing the referral without a completed Referral Form and all supporting documentation.

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FOR WAYPOINT USE ONLY	Date Received:		Account #:	

Client / Patient Information

Last Name, First Name:				Pronouns:	
DOB *(dd/mm/yyyy)*:		Preferred Name:			
Address:					
Contact Numbers:					
Email Address:					
Gender:	☐ Female ☐ Male ☐ Trans Man ☐ Trans Woman ☐ Two Spirit ☐ Nonbinary ☐ A gender identity not listed above:				
Does client / patient self-identify as:	☐ First Nations ☐ Inuit ☐ Métis ☐ Urban Indigenous				
Interpreter Required? ☐ Yes	Language:				
Health Card Number:		Version Code:		Expiry Date:	
Does client / patient have insurance coverage? (i.e. Private, Canadian Dental Care Plan)	☐ Yes ☐ No				
Insurance Provider:		Policy ID:			

Consent

(Indicate Yes or No in each section if patient is able to provide consent)

Medical Treatment	☐ Yes ☐ No	Finances	☐ Yes ☐ No
Psychiatric Treatment	☐ Yes ☐ No	Release of Personal Health Information	☐ Yes ☐ No

Referral Source Information

Referral source name:		Date *(dd/mm/yyyy)*:	
Relationship to client / patient?			
Telephone #:		Fax #:	

If referral not completed by primary care provider, please complete the fields below.

Primary care provider name:		Aware of referral?	☐ Yes ☐ No
Telephone #:		Fax #:	
Referral completed by:		Contact #:	

Your submission of this referral form will be taken to explicitly mean that you have obtained appropriate permissions for releasing the information contained in this referral form to Waypoint Centre for Mental Health Care (the agencies) and Services to whom you are submitting this referral form. If applicable, please include your Organization's Consent to Release of Personal Health Information Form.

Current Community Support / Services Contact Information

Contact name:		☐ PG&T ☐ SDM ☐ Other:	
Telephone #:		☐ Cell ☐ Home ☐ Work	
Telephone #:		☐ Cell ☐ Home ☐ Work	
Permission to leave voice mail? ☐ Yes ☐ No			
List of Natural Supports, Support Services, and Frequency:			

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Referral Information

Psychiatric diagnosis:

Name of patient's psychiatrist:

Reason for referral: (Goals for referral, current / presenting symptoms, relevant psychiatric history, previous interventions tried)

Treatment and Recovery History:

Substance use: ☐ None Does patient want help with this issue? ☐ Yes ☐ No

Substance	Route (IV, oral, inhalation)	Amount	Frequency	Length of Use (days, months, years)	Current Use Y/N (date of last known usage)	Treatment (NRT, OAT, etc.)
Alcohol						
Cannabis						
Nicotine / cigarettes / vape						
Opioids:						
Stimulants:						
Benzodiazepines / Z-Drugs						
Other:						

Relevant medical / developmental / history / medical stability:

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Personal hygiene:	☐ Independent	☐ Needs prompts	☐ Needs assistance	
Senses:	☐ Visual impairment	☐ Hearing Impairment	☐ Sleep concerns	
Communication:	☐ Receptive challenge	☐ Expressive challenge		
Ambulation:	☐ Without assistance	☐ With assistance	☐ Unsteady	☐ Wheelchair/walker
Other equipment / additional comments:				
Eating:	☐ Independent	☐ Requires prompts	☐ Requires assistance	

Legal Involvement

Current charges?	☐ Yes	☐ No	Probation?	☐ Yes	☐ No
Community Treatment Order?	☐ Yes	☐ No	Expiry date *(dd/mm/yyyy)*:		
Other (Disposition Order, Court Diversion)					

Current Patient / Client Risks

Describe your patient / client's current risks in the following categories

Risk of Harm (self and / or others):
Medical, Substance Use, and Psychiatric Co-morbidity:
Current Levels of Stressors:
Engagement and Recovery Status:

Medication List

Include prescription, vitamins, over the counter medications, and herbal supplements

Medication	Dose / Units	Route	Frequency	Instructions / Comments
☐ See attached Medication List / copy of Medication Administration Record				