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 ☐yes ☐no	
First:	Home #:				
DOB (yyyy-mm-dd):	Business #:				
Gender: ☐ Male ☐Female ☐Other:	Email:				
HN (ON-5555555132-VC):	Best contact method: ☐Mobile ☐Home ☐Business ☐ Email				
Address:	Street Address	Line 2	City/Town	Province	Postal Code

Section B: Additional Patient Information					
Sex assigned at birth: ☐ Female ☐Male ☐ Intersex ☐ Unknown					
Pronouns: ☐She/Her ☐He/Him ☐They/Them ☐ Other:					
Preferred name:					
Preferred language: ☐English ☐French ☐Other *(please specify)*: ☐ Interpreter required					
☐ Alternate contact	Contact name:* Relationship:				
	Alternate Contact Phone #:				
Is Alternate Contact the appointment booking contact? ☐Yes ☐ No	☐Unsafe contact persons **(do not speak with):**				
	☐Only speak with patient directly				
Accessibility Concerns or Disability					
☐Falls Risk	☐ Mobility	☐Hearing	☐Vision	☐Other	
Details of special considerations:					

Section C: Additional Referral Information	
☐ Currently followed by a psychiatrist (within past 6 months)	Psychiatrist name:* Psychiatrist Phone Number:
☐Currently receiving support/treatment from any MHA organization/programs/ provider	*Please describe:*
Triage Considerations	
Requested Priority:* ☐Routine ☐Urgent (if urgent, provide reason):	
☐Referral for child or youth (<18 years) ☐Children's Aid Society Involved	*Custody Status (e.g. parents together, shared, sole, informal arrangements): **
☐Currently pregnant or <12 months post-partum	*Please describe (e.g. estimated delivery date, birth date, birth site):**
☐Recent Hospitalization or ER Visit for this issue	*Please describe (e.g. date, reason for hospitalization):*
Concern(s) / Indication(s) Triggering Referral*	
☐Anxiety or Panic Symptoms	☐Emotional Dysregulation (e.g., anger, aggression, mood swings)
☐Bipolar / Mania Symptoms	☐Depressive Symptoms or Low Mood
☐ Obsessions or Compulsions	☐Difficulty coping with life stressors (e.g. grief, loss)
☐Behavioural Addictions (e.g., gambling, internet use, gaming, sexual)	☐Psychotic Symptoms (e.g., hallucinations, delusions, etc.) ☐First Episode of Psychosis
☐Trauma-Related Symptoms / PTSD (e.g., hypervigilance, flashbacks)	☐Personality-Related Concerns (e.g., unstable relationships, chronic conflict with others)
☐Dementia-Related Behaviours	☐Substance Use Concerns *(specify):*
☐Eating Concerns (restricted or binge eating)	*** Complete Section G if selected**
☐Other *(please specify):*	

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Reason for Referral:*

*Clinical Question / Goal(s) of Referral with Relevant History, Management and Investigations**

[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.

☐Counselling / Psychotherapy Services	☐Case Management	☐Supportive Housing
☐Stabilization on Opioid Agonist Therapy	☐Peer Support Services	☐Family Support Services
☐Substance Use / Addiction Treatment	☐Withdrawal Management	☐Court Support

☐ Bed-based Addiction Services (formerly known as Residential Addictions Services)

☐Psychiatry Consultation *(select all that apply):*

☐ Diagnostic Clarification ☐ Medication/Treatment Recommendations ☐rTMS ☐ECT

☐Other Services *(please specify):*

Section D: Current Risks

☐Possible Safety Concern to Others (e.g. aggression, homicidal threats or ideation)		☐Legal Involvement / Court Orders (e.g. current charges, probation, parole, CTO/ORB conditions)	
☐Suicidal Ideation or Attempt	☐Self-Harm Behaviours	☐Housing Instability	☐Other

If selected, please describe:*

Section E: Medical/Mental Health History

☐CPP attached ***Please delete any sensitive information you do not intend to share from the CPP***

Past Medical/Mental Health History ☐*Relevant medical history /notes attached*	
Current Medications (*name, dose, frequency)* ☐List attached	

Section F: Referring Provider Information

Name:		Role: ☐Primary Care Provider (PCP) ☐Other:			
Phone:		Fax:		Billing #:	
Address:					
	Street Address	Line 2	City/Town	Province	Postal Code
PCP Name:		☐PCP same as referring provider		☐Patient does NOT have a PCP	

Signature: **Date:**

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Section G: Additional Eating Disorders Questions *(only complete if "Eating Disorders" selected above)*	
Previously received eating disorders treatment ☐No ☐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 *	
	(Please describe (e.g., frequency, duration):
☐Food Intake Restrictions	
☐Binge Eating	
☐Induced Vomiting	
☐Laxative Use	
☐Exercise Quantity (per week)	
☐Chewing and Spitting	
☐Diet Pills	
☐Other	
Please attach the following*:	
• 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	