Lakeridge Health

## Lakeridge Health Ajax Pickering Site
## Adult Mental Health Outpatient Day Treatment Program

# Referral Form (Adult Only)

**Fax: 905−440−7560**

**Referral Date:** _____

## Please include patient's EMAIL address
## Clinician is calling from a blocked number

**Patient's Name:** _____ DOB: _____

Address: _____

Telephone: _____ Health Card Number: _____

**EMAIL:** _____

**Referring Doctor/Psychiatrist:** _____

**Fax #:** _____ **Phone #:** _____

**Programs: Virtual Classes**

☐ Day Hospital
Mon−Fri for 3 weeks (15 groups) 5 groups/week

☐ Day Treatment
**Phase 1:** Mon, Wed, Fri for 3 weeks (9 groups) 3 groups/week
**Phase 2:** Tue & Thu for 3 weeks (6 groups) 2 groups/week

☐ Individual Telephone Support
(up to 9 week sessions)

**Injection/Clozaril Clinic:** (only for LH Ajax Psychiatrists)

☐ Clozaril Clinic
☐ Depot Clinic

**Relevant History or Injection order:** (Please attach history or use back of page re: diagnosis, length of illness, problems/stressors, abuse history, etc.)

**Date Received:** _____ **Assigned to:** _____