Mental Health Resources Referral Form:

Opioid Supports, Withdrawal Management Supports, Psychiatry Services (includes RAP/RASP)

CLIENTS CAN SELF-REFER TO OTHER SERVICES BY CALLING 1-855-922-1122

Please inform your client that this referral is being made. NSH is a teaching facility; other learners may be involved in care.

Clinical Alerts

Do not fax **urgent referrals** to the MHAP Intake Team. This pathway is not intended for urgent or high-risk situations (e.g., active suicidality, need for hospitalization, etc.); follow existing protocols or direct the patient to the nearest ED.

Submission: Fax all completed pages to the appropriate Intake Office. **Incomplete forms may be returned**.

Halifax, Eastern Shore, West Hants: **902-461-2129**	Colchester−East Hants, Cumberland, Pictou **902−461−7780**
South West, South Shore, Annapolis Valley **902−678−4750**	Cape Breton, Antigonish, Guysborough **902−567−3634**

***Date of referral:** YYYY / MON / DD

* *Indicates a required field*

***Section A Client / Patient Information**	**Referring Provider Information**
Name: _____ Preferred Name: _____ Preferred Pronouns: _____ Phone Number: _____ Full Address: _____ Date of Birth: YYYY / MON / DD Health Card #: _____ Expiry Date: _____ Parent/Guardian: _____	Referring Provider: _____ Phone Number: _____ Address: _____ Fax: _____ Are you the patient's primary care provider* ❍Yes ❍No If No, provide Primary Care Provider/Clinic information:

***Section B Reason for Referral**

❑Psychiatry (*Select one*): (youth/adult)

❍ *RAP One Time Consult / RASP (*select all that apply)*:
❑diagnostic clarification ❑medication consult ❑ tx recommendation(s)

❍ Ongoing Psychiatric Care (for individuals with complex or intensive needs)

→ ***Proceed to Section C***

❑ *Opioid Recovery Program (ORP) (adult)

❍ Assessment for OUD and Initiation on Opioid Agonist Treatment (OAT)
❍ Ongoing OAT Management ❍ Other: _____

→ ***Proceed to Section D***

❑Withdrawal Management: (adult)

❍ Inpatient Withdrawal Management (medication assisted, inpatient admission)
❍ Outpatient Withdrawal Management (medication assisted, outpatient)

→ ***Proceed to Section E***

Note: 1. *RAP (Rapid Access Pathway) is a one-time psychiatric consultation. Requests to support ongoing follow-up care, including prescribing or monitoring, ECT or rTMS are not accepted through the RAP pathway.
2. *ORP: Referrals for chronic pain in the absence of a diagnosed **opioid use disorder (OUD)** do not meet service level guidelines for admission to ORP and should be directed to appropriate pain management services.

Referral Forms

NSMHREFO

Psychiatry Requests, Opioid Recovery Program and Withdrawal Management
REFERRAL FORM

Consent to Contact Patient / Client / Delegate

By confirming the information below, the referral source confirms that the patient gives their consent for the NSH Mental Health and Addictions Program to contact them regarding this referral.

❑Patient / Client ❑Delegate If Delegate, specify relationship to patient: _____

Consent to leave voicemail message at primary phone number (listed above) ❑ Yes ❑ No

Consent to mail letters to address above: ❑ Yes ❑ No

If there is an additional phone number to contact, specify: Type (e.g., office, cell, etc.) and #: _____

Consent to leave voicemail at second contact number ❑ Yes ❑ No

***Section C: Psychiatry Requests**

1. Please provide details of the presenting concerns:

2. Medication details

a) Please provide details of all current psychiatric medications (duration, efficacy, tolerability and dosage).

b) If medication has been discontinued, why?

3. Describe any other services the patient has tried or is currently trying (psychotherapy, group therapy, etc.**):**

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4. Provide any other relevant information that would be helpful for the attending psychiatrist:

***Section D: Opioid Recovery Program (ORP) Requests**

1. If currently prescribed Opioid Agonist Treatment medication, please indicate medication details below:

❑ Buprenorphine/naloxone (Suboxone ®) ❑Long-Acting Injectable Buprenorphine-LAIB (Sublocade ®)

❑ Methadone ❑Slow-release oral morphine (SROM) .

❑Other: _____

Dose: _____ Dispensing schedule: _____

2. **Pharmacy Name/Location:** _____ Prescription end date: YYYY / MON / DD

If on LAIB date of last injection: YYYY / MON / DD

3. History of overdose or poisoning?
❑Yes ❑No ❑Unknown

Naloxone discussed/ provided?
❑Yes ❑No ❑Unknown

If yes, when: _____

4. **Please provide any additional relevant information that may support this referral** (e.g., recent bloodwork, EKG, treatment for Hepatitis C or HIV, housing instability, pending incarceration, pregnancy, concurrent substance use or psychiatric concerns).

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***Section E: Withdrawal Management Requests**

1. **What are the primary substance details (please list all that would be considered problematic)**

2. **Please provide details on usage patterns:**

Frequency (daily, weekly, etc): _____ Route of usage (injection, ingestion, etc): _____

Amount used: _____ Last date of use: YYYY / MON / DD

3. **Is there a history of complications with withdrawal**: (e.g. seizures, delirium tremens)?

4. **Are there any risk factors or comorbidities that need to be considered (**medical/psychiatric – such as cardiac or liver concerns, pregnancy, previously diagnosed mental health concerns**)**?

5. **Are there any barriers to accessing outpatient care** (e.g., transportation, ability to attend daily, etc.)?

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Section F: Referral Preference

All referrals are managed centrally via MHAP Intake and are optimized to connect patients with a psychiatrist who can see them soonest within their zone.

❑ Shortest wait time for access within community (if available)

❑ Willing and able to travel outside community for quicker access (if available). Location: _____

All referrals are managed centrally via MHAP Intake and are optimized to connect patients with a psychiatrist who can see them soonest within their zone.

Section G: Supporting Documentation Attached? ❑Yes ❑No

NOTE: If supporting documentation is not already in the NSHealth EMR (Meditech/OneContent) - please include the following information with referral (if possible):

- Relevant lab and test results, Medication sheet, Previous psychiatric consultations or discharge summaries
- Medical reports, physical findings and / or psychological findings