Patient Name: _____
Date of Birth: _____ (YYYY/MON/DD)
Health card #: _____
Patient Phone: _____

REFERRAL/REQUEST FOR CONSULATION FORM
MOOD DISORERS PROGRAM

Please complete form with client/patient and fax to 902-473-4877 or email to: mood.disorders@nshealth.ca

INFORMATION FOR YOUR CLIENT/PATIENT:

- Please ensure for client/patient is aware of that the referral is being made.
- **Mood Disorders Program** will attempt to contact client/patient and leave a voicemail when consent is provided. If patient cannot be reached. The referring provider will be notified. Note the number will appear as Nova Scotia Health (NSH).
- Given NSH facilities are teaching institutions, your client/patient can expect to have residents or students involved in their care.

INFORMATION FOR REFERRER

- Requires referral by a physician except where there is an evolving first onset mania or for Bipolar I education group.
- Bipolar disorder or major depressive disorder not due to other major psychiatric illness, physical/psychological trauma, or substance abuse.
- We do not accept referrals of client/patients with current primary issues of substance dependence, legal problems, or disability assessments.

Date of referral (YYYY/MON/DD): _____

Services requested:

□ **Consultation**
□ **Consultation and follow up, if indicated**
□ **Referral to a research study**
□ **Request for Transfer of Care**
□ **Referral Bipolar Registry**

Please, provide the following details
Consultation
Question(s)_____

Please carefully review our inclusion and exclusion criteria below.

Inclusion Criteria	**Exclusion Criteria**
• Consultations to psychiatrist on patients with primary severe mood disorders (bipolar or major depressive disorder), if patient will continue to be followed by a psychiatrist in the province. • Diagnostic clarification and/or treatment recommendations for family physicians regarding bipolar I disorder, recent first onset mania, severe and difficult to treat major depressive disorder, bipolar disorder or depression with family history of bipolar disorder or completed suicide.	• Bipolar disorder or major depressive disorder secondary to substance use, major trauma, or other major physical or mental disorder. • Primary issue is substance use disorder, legal problems or assessments for insurance purposes.
CLIENT/PATIENT INFORMATION	**REFERRING PROVIDER INFORMATION**
Legal Name: Preferred name: Pronouns: Parent/Guardian: Phone Number: Full Address: Date of Birth (YYYY/MON/DD): Health Card #: Expiry date (YYYY/MON/DD):	Referring provider: Phone Number: Full Address: Fax: **If applicable (e.g., trainees, residents)*, Name of supervisor:_____
Are you providing regular follow-up to this patient? ☐ No – Name & contact information for the clinician providing regular follow-up:_____ ☐ Yes – Date of next appointment:_____	

Patient Name: _____
Date of Birth: _____ (YYYY/MON/DD)
Health card #: _____
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Is there a need for an interpreter? ❑ Yes ❑ No If yes, please specify which language:
Are there any accessibility concerns? ❑ Yes ❑ No If yes, please specify:

CONSENT TO CONTACT PATIENT/CLIENT/DELEGATE:

By confirming the information below, the referral source confirms that the client/patient gives their consent for the NSH Mood Disorders 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, please specify type (e.g., office, cell, etc.) and number:
Consent to leave voicemail at second contact number: ❑Yes ❑ No
Consent to communicate via email: ❑Yes ❑ No Email address: _____

INDICATION:

□ Consultation regarding any primary Mood Disorder* for a specific question (provide additional details (e.g. diagnostic, pharmacological)
□ Recent onset of Bipolar I disorder (within 3 years)
□ Major Depressive Disorder with family history of Bipolar I disorder or completed suicide
□ Major Depression with melancholia or psychosis

HISTORY: (please provide short description of all that apply - including if past and/or present):

Current treatment: _____
_____
Date of last treatment change: _____
Past treatments (please include supporting documents): _____
_____
Family History: _____
_____
Trauma History: _____
_____
Drug/alcohol use
☐ Present (specify) _____
☐ Past (specify) _____
☐ Current treatment (specify) _____
Medical history: _____

TO BE COMPLETED WITH CLIENT/PATIENT:

Goals for treatment: 1) _____
2) _____

Potential barriers to participating in program (childcare, work schedule, transportation, etc.): _____
_____

Plan to address/problem-solve barriers while on waitlist: _____
_____

I have received information about the program (Mood Disorders Program): ☐ No ☐ Yes

Completed By: **Date Completed:**

_____ _____ _____
(Please print name and credentials) **Referring Clinician Signature** **(YYYY/MON/DD)**

If your client/patient is at immediate risk of harming themselves or others, the client/patient should be directed to the nearest Emergency Department for assessment. Please ensure all patients are provided with the 24/7 provincial Crisis Line (1−888−429−8167) and Emergency resource information.

Please include the following (if possible): Relevant lab and test results, Medication sheet, Previous psychiatric consultations or discharge summaries, medical reports, physical findings and / or psychological findings.

REFERRAL MAY NOT BE ACCEPTED IF INCOMPLETE OR ILLEGIBLE