COMMUNITY MENTAL HEALTH PROGRAM
The Whitby Mall, 1615 Dundas Street, Lang Tower, 2nd Floor, Suite W214
Whitby, Ontario, L1N 2L1 Tel. (905)576-8711 ext.6029 Fax. (905)434-7716

Lakeridge Health

INTERACT

INTERACT PROFESSIONAL REFERRAL FORM

Interact is a **GROUP TREATMENT** program where clients receive service once per week for a limited period of time. This referral form uses a decision tree format to support referring professionals in determining if their client's psychotherapy treatment needs can be addressed by the mandate of the Interact program. If your responses to the Section1 questions indicate your client is appropriate for referral to INTERACT, please proceed with completing the form and forward the entire form to INTERACT. New referrals are reviewed weekly by the team. You will be informed by letter of the outcome of your referral. We may also contact you and/or the client should we have further questions in order to process the referral. Please note that our waitlist fluctuates depending on the volume of referrals and client needs. Should you have any questions about a referral, please contact one of the following team members: Dr. Gary Johnston, PhD, CPsych @ 6240; Karen Lewis, MSW, RSW @ 6243; or Nicole Masil, MSW, RSW @ 6241.

#	**Section 1** These questions are focused on determining basic inclusionary and exclusionary patient profiles.	**Answer** (please circle response)	**Comment Section** (please write legibly)
1	Is your patient's primary reason for referral to Interact best described as unipolar depression and/or anxiety?	YES NO	If NO, then they are NOT suitable for referral to Interact.
2	Is your patient in crisis?	YES NO	If YES, then they are NOT suitable for referral to Interact until they have been stabilized.
3	Is your patient actively suicidal?	YES NO	If YES, then they are NOT suitable for referral to Interact until they have been stabilized.
4	Does your patient experience issues with anger that may pose a risk to other members of a group?	YES NO	If YES, then they are NOT appropriate for group therapy at this time. We recommend individual therapy or an anger management program.
5	Is your patient in agreement with participating in group therapy treatment?	YES NO	If NO, then they are NOT suitable for referral to interact as **we are a group therapy treatment program.**
6	Does your patient need further assessment to clarify the nature of their mental health problems?	YES NO	If YES, they are not currently suitable for Interact. We **do not offer diagnostic assessment services.**
7	Does your patient experience emotion dysregulation that would interfere with group cohesion and therapeutic benefits for group members?	YES NO	If YES, please consider further stabilization prior to referring to Interact.
8	Is your patient currently diagnosed with post-traumatic stress disorder (PTSD) and requiring treatment to address active PTSD symptoms?	YES NO UNCERTAIN	If YES, then they are NOT suitable for referral to Interact. If they have been diagnosed with PTSD and have received PTSD specific treatment they may be appropriate for referral to Interact. If UNCERTAIN, then they probably need further assessment and Interact cannot provide it.
9	Is your patient currently being referred to or actively involved in more than one treatment service, e.g., Interact, Mental Health Day Treatment, Ontario Shores, Catholic Family Services, Family Services Durham?	YES NO	IF YES, please indicate which services.
10	Does your patient have access to an EAP program through their own or their spouses' insurance plan?	YES NO UNCERTAIN	If YES, we suggest they exhaust these resources first before accessing Interact.

#	Section 2 These questions focus on your clinical impressions of the patient's current treatment needs and mental health history.	Answer (please circle response)	Comment Section (please write legibly)
11	Is your patient currently being followed by a psychiatrist or have they been followed by a psychiatrist in the past?	YES NO	If YES, who? ☐ Currently_____ ☐ Previously_____
12	Is your patient currently being treated with any psychiatric medications?	YES NO	If YES, briefly list them.
13	Do you consider your patient's unipolar depression/anxiety problems to have been primarily caused by psychosocial events?	YES NO	If YES, please check all that apply: ☐ work-related ☐ family/marital/relational ☐ history of abuse/adverse events ☐ recent death or loss ☐ Other_____
14	Would you consider your patient's depression/anxiety problem to be chronic (> 5 years)? Please offer your comments regarding the person's ability to benefit from a brief therapy treatment model and treatment expectations in the box to the right of the Answer column.	YES NO	
15	Will your patient require assistance to complete forms?	YES NO	If YES, please check all that apply: ☐ learning disability ☐ low literacy skills ☐ visual limitations ☐ physical limitations ☐ Not sure ☐ Other_____
16	Please share any medical information about your patient or other information you believe will assist us in addressing your patient's mental health treatment needs.		
17	Patient Contact Information Note: The contact numbers you provide us should be cleared with your patient for leaving them a detailed message.	Name: DOB (dd/mm/yy): Health Card#: Address: City: Postal Code: Contact # 1: Contact # 2:	
18	Referring Physician Information By sending this referral and signing you are confirming that your patient is medically cleared to seek treatment at Interact CMHP.	Name: Address: City: Postal Code: Phone#: Fax#: Signature: _____ Date (dd/mm/yy):	