



Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

PHN: \_\_\_\_\_

Practitioner: \_\_\_\_\_

Address: \_\_\_\_\_

PRACID: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone #: \_\_\_\_\_

Email: \_\_\_\_\_

Fax #: \_\_\_\_\_

**\*\*PATIENT EMAIL ADDRESS IS REQUIRED\*\***  
or will automatically be declined

**Shared Care Referral Form**

**Patient Eligibility** (must meet **all** criteria):

- Age 18 - 70
- Referrals from primary care providers located in Medicine Hat for patients residing in Medicine Hat
- Chronic anxiety and depression symptoms impairing the patient's quality of life
- Has failed at least 3 antidepressant trials (non-response or intolerance)  
Failed trials: 1) \_\_\_\_\_, 2) \_\_\_\_\_, 3) \_\_\_\_\_
- Not actively suicidal (requires higher level of care)
- Moderate to severe symptoms, but not requiring a higher level of care such as case management
- No severe active substance use issues
- Depression and anxiety symptoms not deemed primarily caused by substance use
- No history of violence/ physical assault towards others
- No history of psychosis or well-established bipolar

Referral must include **both** of the following to be processed:

- a recent clinical note pertaining to the reason for referral
- previous psychiatric consult notes (Note: we may require a referral directly from psychiatrist)
  - (if applicable) patient is under the care of psychiatrist Dr. \_\_\_\_\_

Clinical background (personality traits, suicidality, diagnosis, comorbidities, patient goals):

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Referring physician agrees to continue their care once patient has completed treatment at Reconnect Mental Health

Primary Care Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_