RECONNECT
MENTAL HEALTH

Reconnect Mental Health
Phone: 1-403-527-8468
Fax: 1-587-824-2606
Website: reconnectmentalhealth.com

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 region
- ☐ 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 (this would require a higher level of care)
- ☐ Moderate to severe symptoms (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 confirmed bipolar disorder

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):

_____

_____

_____

_____

_____

_____

_____

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

Primary Care Provider Signature: _____ Date: _____