camh IMPACT
Individualized Medicine: Pharmacogenetic Assessment & Clinical Treatment

IMPACT RESEARCH STUDY REFERRAL - KIT STATION

Date of Referral:_____
(dd/mm/yyyy)

Use last page to provide additional information

Client/Patient Information

Legal Name:_____
(last name, first name)

Preferred Name
(if applicable):_____

Date of Birth:_____ Age:_____
(dd/mm/yyyy)

Sex/Gender: ☐Female ☐Male

Telephone number(s) (specify home, office, cell, etc.)
Tel:_____

Tel:_____

Can confidential message be left on client/patient voicemail? ☐Yes ☐No

Email:_____
Address:

-

Health Card #:_____ Version code:_____

Referring Source Information

Name:_____
(last name, first name)

Check one: ☐Family Physician
☐ Nurse Practitioner
☐ Psychiatrist
☐Other (specify) _____

Tel:_____

Fax:_____

Email:_____
Address:_____

Is client/patient's current psychiatrist aware of referral (**if not referred by a psychiatrist)**?
☐Yes ☐No ☐Unknown
☐Does not have psychiatrist

Name of Psychiatrist (if applicable):

_____
(last name, first name)

Does the referring source wish to receive a consultation report? ☐Yes ☐No

Is client/patient (or substitute decision maker) aware of and in agreement with the referral and that he/she will be seen? (check one): ☐Yes ☐No (If **No**, please explain): _____

Are there any other barriers to communication and/or accessibility with this client/patient?
☐No ☐Yes (please specify):_____

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Send to:
Dr. James L. Kennedy
The IMPACT Team
Centre for Addiction and Mental Health (CAMH)
250 College Street
Toronto, ON M5T 1R8
Phone: 416-535-8501 ext. 30240
Fax: 416-979-4666
Email: impact@camh.ca

1. WORKING DIAGNOSIS/CLINICAL PROBLEM(S)

WORKING DIAGNOSIS (CHECK ALL THAT APPLY)	SPECIFY CURRENT CLINICAL PROBLEMS	RELEVANT HISTORY
Anxiety ☐	☐ Social ☐ Panic ☐ OCD ☐ Generalized	
Bipolar ☐	☐ Mania ☐ Depression ☐ Mixed Episode ☐ First Episode Mood with Psychosis	
Depression ☐	☐ Hallucinations ☐ Delusions	
Schizophrenia / Spectrum Illness ☐	☐ Hallucinations ☐ Delusions ☐ First Episode Psychosis	

2. RISK ISSUES

RISK ISSUE	CHECK IF YES	IF YES: WHEN?	DETAILS
Suicide attempt/ideation			
Deliberate self-harm			
Violent behaviour			
Legal involvement			
Addictions issues			
Behavioural issues			

3. CURRENT MEDICATIONS (Psychiatric) *attach additional information if needed*

MEDICATION	DOSE / FREQUENCY	RESPONSE & ADVERSE EFFECTS

4. PAST MEDICATIONS (Psychiatric)

MEDICATION	DOSE / DURATION	RESPONSE & ADVERSE EFFECTS

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5. PAST PSYCHIATRIC/ADDICTIONS HOSPITALIZATIONS (attach discharge summaries)

FACILITY	DATES (dd/mm/yyyy)	REASON

6. RELEVANT MEDICAL HISTORY (e.g. endocrine, neurological, respiratory, cardiac, or other issues)

7. METABOLIC ISSUES

ADDITIONAL INFORMATION
(e.g. client/patient strengths, current and/or past medications; additional medical history; other comments)

Completed by:

(print name and credentials) (signature) Date: (dd/mm/yyyy)

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8. PROPOSED TREATMENT (FOR REFERRING CLINICIAN TO COMPLETE):

Imagine that you had not ordered pharmacogenetic testing for this patient. How would you have proceeded with their treatment (e.g. maintain current therapy, augment, switch, titrate off, initiate psychotherapy, etc.)? If additional medications, which medication and why?

Completed by:

_____ _____ Date:_____

(print name and credentials) (signature) (dd/mm/yyyy)