Lakeridge Health

Lakeridge Health Ajax Pickering Site
Adult Mental Health Outpatient Day Treatment Program

Referral Form (Adult Only)

Fax: 905−683−8527

Referral Date: _____

Please include patient's EMAIL address
Clinician is calling from a blocked number

Patient's Name: _____ DOB: _____

Address: _____

Telephone: _____ Health Card Number: _____

EMAIL: _____

Referring Doctor/Psychiatrist: _____

Fax #: _____ **Phone #:** _____

Programs: Virtual Classes

☐ Day Hospital
Mon−Fri for 3 weeks (15 groups) 5 groups/week

☐ Day Treatment
Phase 1: Mon, Wed, Fri for 3 weeks (9 groups) 3 groups/week
Phase 2: Tue & Thu for 3 weeks (6 groups) 2 groups/week

☐ Individual Telephone Support
(up to 9 week sessions)

Injection/Clozaril Clinic: (only for LH Ajax Psychiatrists)

☐ Clozaril Clinic
☐ Depot Clinic

Relevant History or Injection order: (Please attach history or use back of page re: diagnosis, length of illness, problems/stressors, abuse history, etc.)

Date Received: _____ **Assigned to:** _____