



Adult Psychiatric Clinic Referral Form

PLEASE FAX to 866-821-5992

Patient Information

NAME: Last _____ First _____

PHN: _____ DOB: _____ Gender _____ Phone: _____

Address: _____ City: _____ Postal code _____

E-mail: _____

Next of Kin: _____ Relationship to Patient _____ Phone: _____

Referring Practitioner

Name: _____ MSP BILLING NUMBER _____

Office Address _____ City: _____ Postal Code: _____

Office Fax: _____ Office Phone: _____

Reason for Referral: Attach relevant information such as EMR notes, previous consults, and hospital discharge summaries.

Aggressive Behaviour? Yes No

If answering yes, please describe behavior(s) and whether it is current or past: _____

Suicidal or Psychotic Behaviour? Yes No

If answering yes, please describe behavior(s) and whether it is current or past: _____

Substance Abuse? Yes No

If answering yes, please describe behavior(s) and whether it is current or past: _____

Current Medications and Allergies (if any): _____

Has the patient had previous contact with mental health professionals including school counselors, psychologists or social workers? Yes No

If answering yes, please list the professionals and whether there is ongoing contact: _____
