 **Psychiatry Referral Form- Dr. Mazhar**

*One-time psychiatric consultation, or short-term care in some cases, is arranged for adults with the understanding that referring physician will follow up on recommendations.*

Valid Provincial health coverage required for referrals.

Exclusion Criteria:

* Actively suicidal or homicidal, requiring crisis assessment or hospital admission (please refer patients to the local emergency department for urgent assessment)
* Assessments for legal purposes including family court or forensic psychiatry
* Completion of forms for insurance, WSIB or third-party assessments
* ADHD, Autism or Neurodevelopmental assessments
* Subspecialty or Multidisciplinary assessments

Patient Information:

Patient’s Last Name : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient’s First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: (DD/MM/YY) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: Male Female Other

OHIP No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Version: \_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Alternate phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Language: English Urdu/Hindi Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provisional Diagnosis/ Presenting Problem

Previous psychiatric treatment including hospitalization:

**Please forward any reports regarding previous psychiatric treatment and recent lab tests if applicable**

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

Medical History:

Current Medications:

Allergies:

Referral Source Information:

Are you agreeable to provide care to this patient after one time consultation or short-term psychiatric care?

Yes No

If no, please indicate who will resume care or follow up: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Source Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GP NP Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Source CPSO #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referral Source OHIP Billing #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Source Phone #. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referral Source Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referrer Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Please ensure that patient has consented to the referral. **Please fax your completed referral to: 365-877-1666**

**Clinic Use Only:**

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| --- | --- |
| Date referral received: |  |
| Date referral screened: |  |
| Referral accepted: | Appointment scheduled for:  An appointment will be scheduled at a later date |
| Incomplete referral. Please provide information on the following: |  |
| Referral declined: |  |
| Unable to schedule appointment: | Unable to contact patient  Appointment declined by the patient  Other: |