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Psychiatric Consultation Referral Form

Referral Date: _____ (DD/MM/YYYY)

Is the patient aware of this referral? ☐ YES ☐ NO

☐ Adult Psychiatric consultation (26+)

☐ Youth Psychiatric consultation (16-25)

Specialized Services: ☐ Esketamine ☐ Transcranial Magnetic Stimulation ☐ Clinical Trials

Referring Provider: ☐ Physician \ NP: _____ ☐ Allied Health Staff: _____

Referring Provider OHIP Billing Number (if applicable): _____

Office Phone: ( ) _____ Office Fax: ( ) _____

Reason for referral: _____

Please enclose all relevant psychiatric documentation

Patient Last Name: _____ Patient First Name: _____

Date of Birth: _____ (DD/MM/YYYY) Health Card #: _____ VC _____

Home Phone: ( ) _____ Alternate Phone: ( ) _____

Permission to leave voicemail ☐ YES ☐ NO

Street Address: _____ Apartment or Unit _____

City: _____ Province: _____ Postal Code: _____

Medical Comorbidities / Risk Factors:

_____

_____

_____

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