Queensway Carleton Hospital

PATIENT INFORMATION

AFFIX PATIENT LABEL HERE

MENTAL HEALTH SERVICES

Outpatient Psychiatry Consultation Form

PLEASE NOTE: Patients referred are expected to call the Outpatient Psychiatry Department (613-721-4708) to activate their referral.

*****INCOMPLETE REFERRALS WILL BE FAXED BACK & WILL DELAY THE REFERRAL PROCESS***

WE DO NOT OFFER: Opinions for third party such as CAS, court, insurance, workplace issues, custody, or disability claims.

REFERRING PROVIDER INFORMATION (Please print)

Referral Date: _____

Referring Physician: _____ Billing no: _____

Telephone no: _____ Fax no: _____

Please describe your clinical questions as specifically as possible:
(Stating only a diagnosis is insufficient and referrals lacking clinical details will be returned)

Symptom Profile Mood ☐ Y ☐ N Anxiety ☐ Y ☐ N Psychosis ☐ Y ☐ N	Other:
Risk Issues Suicide attempt ☐ Y ☐ N Suicidal Ideation ☐ Y ☐ N Deliberate Self-harm ☐ Y ☐ N Violent behaviour ☐ Y ☐ N	If yes, provide dates & details: (Include all reports with referral)
Substance Use Used within the last **3 months** ☐ Y ☐ N If yes, provide substance used, amount and frequency:	**Active Legal Issues:** ☐ Y ☐ N Details:

Queensway Carleton Hospital

Patient Name: _____

MENTAL HEALTH SERVICES- Outpatient Psychiatry Consultation Form

Recent psychiatric hospitalization? ☐ Y ☐ N (If yes, please attach discharge summary) Comment/What treatment?
Emergency Department visits within the last 6 months for psychiatric care? ☐ Y ☐ N If yes, what treatment?
Has patient tried psychotherapy? ☐ Y ☐ N Details:

MEDICATIONS

Current Medication(s)	***Dose***	***Frequency***	***Date Started***
Past Medication(s)	***Dose***	***Frequency***	***Dates***

Medical History: (Please forward recent lab results and relevant reports)

I, _____, agree to provide follow-up care to this patient.

REFERRING PHYSICIANS ARE REQUIRED TO COMPLETE ALL SECTIONS & FAX TO *613-721-4773*.