HÔTEL-DIEU GRACE HEALTHCARE
ESTD 1888

GENERAL PSYCHIATRY CLINIC
COMMUNITY MENTAL HEALTH
MENTAL HEALTH OUTPATIENT DEPARTMENT

Date: _____ (MM/DD/YYYY)

PATIENT INFORMATION		
Last Name:	First Name:	
Date of Birth: YYYY-MM-DD	Health Card:	Version Code:
Teplephone:		

I am requesting an assessment from the HDGH General Psychiatry Consultation Clinic for this patient. I understand that the service provides a formal psychiatric assessment with recommendations from a psychiatrist, and a copy of the psychiatric consultation with recommendations will be forwarded to my practice. I understand that these formal recommendations may include referrals to other community agencies and services. I am willing to provide follow up as per the recommendations, including provision of medication and appropriate monitoring. I understand that providing the following information is required by the OHIP schedule of benefits and will result in a better client outcome.

Psychiatrist (or designate): _____

Current Diagnosis: _____

Current Treatment: _____

History of the Problem: _____

_____

_____

Previous Psychiatric Consultation/Treatment (date of most recent): _____

_____

Past Medical History (operations, medical admissions, head injuries, seizures etc): _____

_____

All Current Medications: _____

_____

_____

Substance Use: _____

Any Other Relevant Information: _____

_____

_____	_____	_____
OHIP Billing Number	Phone	Fax
_____	_____	_____
Signature	Printed Name of Practitioner	Date (MM/DD/YYYY)

FAX COMPLETED FORM TO: 519-973-1989

4292HD