HÔTEL-DIEU GRACE HEALTHCARE
ESTD 1888

GENERAL PSYCHIATRY CLINIC
COMMUNITY MENTAL HEALTH
MENTAL HEALTH OUTPATIENT DEPARTMENT

Name: _____

D.O.B.: _____

Telephone: _____

Health Card #: _____

Date: _____ (MM/DD/YYYY)

Referring Doctor: _____ Phone: _____ Fax: _____

I am requesting an assessment from the HDGH Community Mental Health Consultation Clinic for this patient. I understand that the service provides a crises assessment with input from both psychiatry and social work, resulting in a treatment plan which may include other community agencies and providers. Formal consultation with a psychiatrist will be arranged according to urgency and availability and a copy of the psychiatric consultation with recommendations will forwarded to my practice. 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: _____

_____ _____
Signature Printed Name of Practitioner

FAX COMPLETED FORM TO: 519-973-1989

_____ _____
Date (MM/DD/YYYY) OHIP Billing Number