

W-PEP REFERRAL

Dr. Cortese, Dr. Villella, Dr. Montaleone

Attending Psychiatrists

1453 Prince Road, Windsor, ON N9C 3Z4

Phone: 519-257-5111 Ext 76380 Fax: 519-257-5188

Name: _____ D.O.B.: _____ (MM/DD/YYYY)

Address: _____ Phone: _____

Health Card #: _____ V.C.: _____

Emergency Contact: _____ Phone: _____

Relationship: _____ Family Doctor: _____

Reason for Referral: Schizophrenia Schizoaffective Delusional Disorder
 Psychosis NOS 2nd Opinion (consult only) Other _____

Please describe the problem(s)/your specific question (attach consult): _____

Past psychiatric history/treating physician: _____

Pertinent medical conditions/past psychiatric hospitalizations: _____

Current medications: _____

Impression of treatment compliance: _____

Use of drugs/substances: _____

Community agencies involved in this patient's care: _____

Any pending or ongoing legal issues: _____

Referring M.D. Information: Name: _____ Physician Billing #: _____

Phone: _____ Fax: _____ Date of Referral: _____ (MM/DD/YYYY)

Please attach any past psychiatric history pertinent to the patient's care.

To be completed by W-PEP Team

Intake Nurse/Doctor: _____

Contact Dates: _____

Assessment Date: _____