

Referral Form

Patient Information

Name:		OHIP #:		VC:
Address:		Date of Birth:		
Telephone # 1:		City:	Postal Code:	
Telephone # 2:		Gender:	Marital Status:	
Language: <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other (specify):				
Living arrangements: <input type="checkbox"/> Alone <input type="checkbox"/> Spouse <input type="checkbox"/> Other Relative <input type="checkbox"/> Friends <input type="checkbox"/> Residential <input type="checkbox"/> Other				

Contact Person

Name:		Relationship:		
Address:		City:	Postal Code:	
Telephone #:		Telephone #:		

Contact Person to arrange appointment:

<input type="checkbox"/> Patient		<input type="checkbox"/> Referring Physician		
<input type="checkbox"/> Other	Name:	Telephone:	Relationship:	

Referring Physician / Source

Family Physician (if different from referring physician)

Name:		Name:		
Address:		Address:		
Telephone #:		Telephone #:		
Fax #:		Fax #:		

Is the family physician agreeable with the referral?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Reason For Referral

Name:

DOB:

Previous Psychiatric Services

- Geriatric Psychiatry Community Services of Ottawa (GPCSO)
- Royal Ottawa Mental Health Centre (ROMHC)
- Known to psychiatrist name: _____

Medical History

List of all Current Medications (Please attach)

Supporting Medical Information (Please attach)

ie: Blood work, CT Scans, X-Ray reports, medications tried, admission/discharge from hospital, consults by geriatric medicine, neurology, psychiatry or other related specialties

Additional Information

(ie: any safety, community health, legal concerns etc.)

Incomplete information may result in a delay in the processing of this referral

THIS SECTION IS MANDATORY FOR ALL REFERRALS

Signature of Attending Physician/NP:

Attending Physician/NP Billing #:

Printed Name of Attending Physician/NP:

Please FAX To 613-562-0259

Tel: 613-562-9777