BLUEWATER HEALTH

Outpatient Psychiatry Referral Form

Patient Information

Urgent: ☐ Yes ☐ No

Legal Name: _____ Preferred Name: _____
(Last Name, First Name)

Date of Birth: _____ (dd/mm/yyyy)

Health Card #:_____ Version Code: _____ Expiry Date _____
(dd/mm/yyyy)

Gender: ☐ Female ☐ Male ☐ Other (please specify) _____ ☐ Prefer not to answer

Telephone number(s) (specify home, office, cell etc.) Tel: _____

Address: _____

Alternate Contact Information

Relationship to patient: _____

Tel: _____ Tel:

_____

For patients 16 years of age and older, consent is required for assessment to be completed. Please ensure that you have spoken to the person about the referral.

Is your patient aware of this referral?

☐ Yes ☐ No If no, please explain: _____

Referral Source Information

Name:_____

Check one: ☐ Family Physician ☐ Nurse Practitioner ☐ Psychiatrist ☐ Other: _____

Tel: _____ Fax: _____

Address:_____

_____

Billing Number : _____

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REASON FOR REFERRAL (e.g. Medication/Treatment recommendations, Diagnostic Clarification)

Why are you referring the patient now? (e.g., current symptoms, presenting problems, history)

_____
_____
_____
_____

RELEVANT MENTAL HEALTH HISTORY

Has the patient been assessed by a psychiatrist in the past? ☐ Yes ☐ No

(if yes, please attach all consultation notes, assessments, results)

_____
_____
_____

RELEVANT MEDICAL/ DEVELOPMENTAL HISTORY (e.g., disabilities, intellectual delay, autism, allergies, endocrine, neurological, respiratory, cardiac, metabolic)

_____
_____
_____

MEDICATIONS (psychiatric and non-psychiatric – attach additional information if needed)

MEDICATION	CURRENT	PAST	DOSE/FREQUENCY	RESPONSE & ADVERSE EFFECTS

COMMUNITY SUPPORTS, HOSPITALS OR THERAPIES INVOLVED WITHIN THE PAST TWO YEARS

_____
_____

Completed by:

_____ _____ **Date:** _____

(print name and credentials) **(signature)** **(dd/mm/yyyy)**