Sinai Health | Mount Sinai Hospital
Joseph & Wolf Lebovic Health Complex

REFERRAL FORM
GERIATRIC PSYCHIATRY

60 Murray Street - Suite L1-012, Toronto ON M5T 3L9
T: 416-586-4800 ext. 5192 F: 416-586-3231

Referring Physician	**Date:**
Name of Referring Physician:	**Specialty & Billing #:**
Main Telephone #: **Fax #:**	**Backline/Unlisted Telephone #:** **Email:**
Address:	**Family Physician's Name & Phone Number:**
Referring Physician's Signature:	**Referral:** ❍ **Urgent** ❍ **Non-Urgent**
Patient Demographics	
Name:	**D.O.B. (DD/MM/YYYY):**
HIN (& Version Code):	❍ **Male** ❍ **Female**
Address & Phone #:	
Should the patient be contacted directly with an appointment? ❍ **Yes** ❍ **No** **If "No", Provide name & telephone number of a contact person:**	
Able to speak English? ❍ **Yes** ❍ **No**	**If "No", language(s) spoken**:
Known Health Conditions & Diagnoses:	
Clinical Problem:	
Expectations of Referring Physician - Clarification of diagnosis, ongoing treatment, etc…	

IMPORTANT: **To facilitate timely processing of the referral & scheduling an assessment for the patient, please:**

- **Ensure** the referral is complete & that the patient's family physician is informed of the referral to our clinic
- **Include** the patient's medical, psychiatric and medication history.
- **Include** relevant consultations and discharge summaries, laboratory results, and radiology/imaging reports; especially any past psychiatric assessments and discharge summaries.
- **Please note:** If we require further information, we will contact the referring physician to follow-up on the referral before confirming our involvement or making an appointment for the patient.

Please Fax Completed Form to 416-586-3231
For more information, please contact 416-586-4800 ext 5192