Clearly imprint patient identification card

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

General Psychiatry Assessment Clinic Referral Form

Department of Psychiatry
600 University Avenue, 9th Floor,
Toronto, Ontario, Canada M5G 1X5
T (416) 586-4800 x 4568 **F** (416) 586-8654
www.mountsinai.on.ca

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Date of Referral: (YYYY-MM-DD):

Exclusion Criteria Includes Patients who:

- are under the age of 18
- have had a psychiatric assessment within the past 12 months
- are currently followed by a psychiatrist
- are referred from hospital/clinics affiliated with departments of psychiatry
- require 3rd party assessments (e.g. lawyer/court, child welfare services, WSIB, psycho-educational)

Note: Patients with primary substance use disorders can self-refer to Metro Addiction Assessment Referral Service (MAARS) (416) 599-1448

Patient Information:		**Referring Physician Information**
Patient Name:		MD Name:
City/Town:		OHIP Billing #
Postal Code:	DOB (YYYY-MM-DD):	Phone:
HCN:	Gender:	Fax:
Phone 1:	Phone 2:	Back Line (unlisted) #:
Email:		Email:
Permission to leave message? ☐ Yes ☐ No		Signature:
☐ Interpreter Services Language:		

Preferred Assessment Service: (please select only 1)

☐ Full psychiatric assessment ☐ 10 minute MD to MD phone consultation ☐ Non-MD psycho-social intervention

Reason for referral/specific question/intervention for which you are seeking input. Current symptoms and stressors:

☐ Suicidal Ideation ☐ Self-Harm ☐ Violent Behaviour ☐ Off work due to mental illness

Current alcohol/substance use:

Has this patient been previously assessed through the Mt. Sinai Psychiatric outpatient service? ☐ Yes ☐ No

Has this patient had previous psychiatric admissions to a hospital? ☐ Yes ☐ No Most recent:

Past Psychiatric/Medical History:

C195

Date of last psychiatric assessment: _____ (YYYY-MM-DD) ☐ **Additional notes included with referral** ☐ **No additional notes**

Current Medications: (please list ALL medications)

Allergies

COPY TO OUTPATIENT PSYCHIATRY RECORD