JOSEPH BRANT HOSPITAL
Mental Health Ambulatory Services

Telephone: (905) 631-1939 Fax: (905) 631-0513

Referral for Geriatric Psychiatry Consultation

ALL REFRRALS TO BE FORWARDED/REVIEWED BY INTAKE COORDINATOR

Referral Date:_____ Referral Source:_____

Referring Physician's Billing #:_____

Patient's Name:_____ DOB:_____ Marital Status:_____

Address/City/Town:_____ Postal Code:_____

Hospital Unit ID # (if known):_____ OHIP # & Version Code:_____

Family Physician:_____ Office Tel #:_____ Office Fax #:_____

Primary Care Provider:

Name:_____

Relationship:_____

Telephone #:_____

Secondary Care Provider:

Name:_____

Relationship:_____

Telephone #:_____

Reason for Referral:_____

Duration of Symptoms:_____

Psychiatric Medication Profile:

Medications:	Date Medication Started:	Prescribed by:

Physical Ailments:_____

Treatment:_____

When was treatment started?_____

Known Allergies:_____

Please include with this referral any investigation results recent or past

Past Psychiatric History :(when did it start, diagnosis)_____

Admissions: ☐ Yes ☐ No Treatment: ☐ Yes ☐ No Suicidal/homicidal attempts: ☐ Yes ☐ No

Signature of Person Completing Form:_____