Montfort

OUTPATIENT MENTAL HEALTH CLINIC
Central Intake – Referral Form

Please fax the completed form to 613-748-4938

Identification (Referred Patient)					
Last Name:			First Name:		
Sex:	W □	M □	Birthdate:		
Address:			OHIP:		
			Language (REQUIRED):	**French □**	**English □**	**Other □**
			Phone 1:		
			Phone 2:		

Clinical Information			
Diagnostic:			
Medication	**Past Medical History**	**Past Psychiatric History**	**Legal History**

Significant Symptoms		
Anxiety □	Hallucinations □	Behavior disorder □
Sad mood □	Paranoia / delusions □	Violence □
Elevated mood □	Impulsiveness □	Gambling problem □
Suicidal □	Attention disorder □	Memory disorder □
Substances □	Eating disorder □	Functional decline □
Other Symptoms:		

Specific expectations of referring physician:

Requested Service	
Psychiatric consultation (return to Physician/Doctor)	
Services available in French only: Group therapy Telehealth	

Exclusion Criteria	
Eating disorders	Autism spectrum
Psycho-legal assessments	Intellectual deficiency
Province of residency other than Ontario	TDHD assessment
Geronto-psychiatry	Long-term follow
Pedopsychiatry	2nd opinion

Date: ___________________________________

Referring Physician/Doctor
Name: Billing # :
Address :   # Phone : # Fax :
□ **I agree that the patient will be returned to my care**

Referring physician/doctor signature:

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