Montfort
Hôpital universitaire
Academic Hospital

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Ottawa, Ontario K1K 0T2
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Mental Health Program
Ambulatory Services

Central Intake / Request for psychiatric consultation

Please fill out the form and fax 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:

CONSULTATION ONLY (Back to Referring MD)	
▪ Pharmacological Recommendations	
▪ Brief Psychotherapeutic Recommendations	
Groups (**FRENCH ONLY**):	
Anxiety Management	
Borderline Personality Disorders (DBT/DBT-light)	
Concurrent Disorders (AGIR)	
Group for Psychotic Disorders (Accept-Action)	
Integrative Day Hospital	
Intensive Day Hospital	
Perinatal psychiatry	
Youth Transition (CAJAR)	
▪ **Other:**	

Date:_____

Referring Doctor
Name:
Billing #:
Address :
E-mail :
Phone #:
Fax #:
I agree that the patient will be returned to my care ☐

Referring Doctor Signature:

_____