Ottawa Geriatric Psychiatry Services Referral Form

The Royal — Mental Health - Care & Research / Santé mentale - Soins et recherche

GPCSO SCGPO

Patient Information

Name:	OHIP #:	VC:
Address:	Date of Birth:	
Telephone # 1:	City:	Postal Code:
Telephone # 2:	Gender:	Marital Status:

Language: ❑ English ❑ French ❑ Other (specify):

Living arrangements: ❑ Alone ❑ Spouse ❑ Other Relative ❑ Friends ❑ Residential ❑ Other

Contact Person

Name:	Relationship:	
Address:	City:	Postal Code:
Telephone #:	Telephone #:	

Contact Person to arrange appointment:

❑ **Patient**		❑ **Referring Physician**			
❑ **Other**	**Name:**	**Telephone:**		**Relationship:**	

Referring Physician / Source	**Family Physician** (if different from referring physician)
Name:	Name:
Address:	Address:
Telephone #:	Telephone #:
Fax #:	Fax #:

Is the family physician agreeable with the referral? ❑ Yes ❑ No

Reason For Referral

Name:	DOB:

Previous Psychiatric Services

- ❑ **Geriatric Psychiatry Community Services of Ottawa (GPCSO)**
- ❑ **Royal Ottawa Mental Health Centre (ROMHC)**
- ❑ **Known to psychiatrist name: _____**

Medical History

List of all Current Medications (Please attach)

Supporting Medical Information (Please attach)

ie: Blood work, CT Scans, X-Ray reports, medications tried, admission/discharge from hospital, consults by geriatric medicine, neurology, psychiatry or other related specialties

Additional Information

(ie: any safety, community health, legal concerns etc.)

Incomplete information may result in a delay in the processing of this referral

THIS SECTION IS MANDATORY FOR ALL REFERRALS

Signature of Attending Physician/NP:

Attending Physician/NP Billing #:

Printed Name of Attending Physician/NP:

Please FAX To 613-562-0259

Tel: 613-562-9777

Revised May2017