

MOUNT SINAI HOSPITAL

Joseph and Wolf Lebovic Health Complex

Bright Minds. Big Hearts. The Best Medicine.



OUTPATIENT PSYCHIATRY REFERRAL FORM

DEPARTMENT OF PSYCHIATRY

600 UNIVERSITY AVENUE

ADMINISTRATIVE CONTACT: DENISE GASPARI

TEL: 416 586-4800x.4568

FAX: 416 586-8654

PATIENT INFORMATION	REFERRING PHYSICIAN INFORMATION
NAME: DOB: ADDRESS: PHONE #: GENDER: OHIP#:	MD NAME: ADDRESS: PHONE #: FAX #: BACK LINE (UNLISTED #) OHIP BILLING #: SIGNATURE: _____

DOES THE PATIENT SPEAK ENGLISH ? YES / NO, SPOKEN LANGUAGE: _____

REASON FOR REFERRAL/ PSYCHIATRIC CONCERNS: PLEASE COMMENT ON SAFETY/SUICIDALITY.

SUBSTANCE USE:

ALLERGIES:

CURRENT TREATMENT: PLEASE LIST: ALL MEDICATIONS, ONGOING THERAPY, TREATMENTS PATIENT IS WAITLISTED FOR
IN THE CASE OF A REQUEST FOR A 2ND OPINION, REFERRAL MUST BE COMPLETED BY TREATING
PSYCHIATRIST.

BRIEF PSYCHIATRIC HISTORY: PLEASE LIST PREVIOUS: DIAGNOSES, TREATMENT, ADMISSIONS, SELF-HARM, VIOLENCE
HAS PATIENT HAD ANY PREVIOUS CONTACT WITH MSH PSYCHIATRY? YES / NO

****PLEASE INCLUDE PREVIOUS PSYCHIATRIC ASSESSMENT/DISCHARGE REPORTS WITH THIS REFERRAL.****
PLEASE FAX REFERRAL TO (416) 586-8654. AN INTAKE CLINICIAN WILL CONTACT THE PATIENT AND/OR
REFERRING PHYSICIAN'S OFFICE FOR FURTHER INFORMATION.

PLEASE NOTE THE FOLLOWING EXCLUSION CRITERIA FOR REFERRALS:

PREVIOUS PSYCHIATRIC ASSESSMENT WITHIN THE PAST 12 MONTHS.
REFERRALS RECEIVED FROM HOSPITALS THAT HAVE PSYCHIATRIC SERVICES.
DIAGNOSTIC ASSESSMENTS THAT ARE BEING REQUESTED FOR LEGAL MATTERS, CAS, WSIB, ODSP.
PRIMARY SUBSTANCE ABUSE. (WE RECOMMEND PATIENTS SELF-REFER TO CAMH/MAARS 416-599-1448.