

**FRENCH LANGUAGE TELEPSYCHIATRY SERVICES (FLTS) PATIENT REFERRAL FORM**

Physician Consultation/ Referral Letters Accepted in Lieu of Referral Form  
Information Requested on Referral Form Should be Included or Attached

Date (dd/mm/yyyy): \_\_\_\_\_

Type of appointment:  New Patient Consultation  Follow-up consultation

Patient/Client information	Referring Source information
Name:	Name:
Date of Birth (dd/mm/yyyy):	Check one: <input type="checkbox"/> Family Physician <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other (specify) _____
Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/>	
Patient aware of Referral: <input type="checkbox"/> yes <input type="checkbox"/> no	
Client Canadian Born: <input type="checkbox"/> yes <input type="checkbox"/> no	
Date of arriving in Canada	
Client's source of income:	
Current employment if employed:	
Living arrangement: If living in a facility, facility name: _____	
Admit date: _____	
Substitute Decision Maker Name/Next of Kin:	
Parent's Names (if under 12):	
Address (if different from patient):	
Phone Number:	
Current phone number:	Phone Number:
Alternate or preferred phone number:	Fax Number:
Address:	Address:
Health Card Number: Version Code: Expiry Date (dd/mm/yy):	OHIP Billing Number:
If known, patient's pharmacy name and phone number:	

**FRENCH LANGUAGE TELEPSYCHIATRY SERVICES (FLTS) PATIENT REFERRAL FORM**

Patient Name: \_\_\_\_\_

OHIP Number #: \_\_\_\_\_

1. Reason for Referral:
2. Relevant Present and Past History:
3. Relevant Physical Findings, Test Results, All Current Medications:

To reduce duplication, information already available in the system is highly valued and should be attached to the referral:

Medical/ Psychological/ Psychiatric History	<input type="checkbox"/> attached	Other assessments	<input type="checkbox"/> attached
Hospital discharge summaries	<input type="checkbox"/> attached	Previous Investigation (e.g. ECG, CT/MRI, Echo)	<input type="checkbox"/> attached
Psychiatric Hospitalization(s)	<input type="checkbox"/> attached	<b>Medications (please attach list)</b>	<input type="checkbox"/> <b>attached</b>
<b>Recent Laboratory Results</b>	<input type="checkbox"/> <b>attached</b>		

**ADDITIONAL INFORMATION / NOTES**

(e.g. additional medical history, comments about medications, potential safety concerns, other health care providers involved in the care of the patient, other comments)

Completed by (print name): \_\_\_\_\_ Date (dd/mm/yyyy): \_\_\_\_\_

Signature: \_\_\_\_\_

Please complete the **two pages** and fax completed form to fax: 519 673-1022

**Please fax completed form to Fax: 519 673-1022** (this is a secure fax line)

For any question or concerns, please call: 519 673-3242 ext 274 or 519 673-3242 ext 271