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

upstream
COMMUNITY MENTAL HEALTH SUPPORT

TELEMEDICINE
Referral Form

Complete and fax to 613.248.1117

PATIENT INFORMATION

Surname		Given Names	
Date of Birth (DD/MM/YY)		Sex ❑ Male ❑ Female	
Maiden Name		Other Name	
Address		Language ❑ English ❑ French	
City		❑ Other	
Province		Home Phone	
Postal Code		Other Phone	
Marital Status ❑ Common Law ❑ Divorced ❑ Married ❑ Separated ❑ Single ❑ Widowed ❑ Other			
Health Card Number	Version	Expiry Date	

REFERRAL SOURCE

Referral Source ❑ Family Physician ❑ Psychiatrist ❑ Nurse Practioner ❑ Other			
Name		Phone No.	
Address		Fax No.	
		Email	
		Billing No.	

REFERRAL DETAILS

Reason for Referral *(please be as specific as possible)*
❑ Mood ❑ Anxiety ❑ Psychosis ❑ Substances ❑ Other
❑ Diagnostic Clarification ❑ Management Recommendations ❑ Community Resources

Diagnosis *(if known)*

Past Psychiatric History (please include documentation if available)

Hospitalizations

Previous Psychotropic Medications

Psychotherapy or Counselling

Medical History

Current Medications

Allergies

COMPLETED BY

As a physician / nurse practitioner your signature indicates commitment to providing follow up and ongoing care to the client.

Signature	Date (DD/MM/YY)