



Adult Psychiatric Clinic - Referral Form

Thank you for your referral to our psychiatric clinic. Please carefully read and complete all sections of this form before submission. Accurate and thorough information helps us better understand the patient's needs and coordinate appropriate services.

***** INCOMPLETE REFERRALS WILL NOT BE ACCEPTED AND WILL BE RETURNED *****

Exclusion Criteria

Before sending the referral, please confirm the following by checking each box:

- Patient has a primary mood-anxiety disorder
- Primary reason for referral is not for the assessment and/or treatment of ADHD or autism spectrum disorders
- Patient does not have active or persistent psychosis
- Patient is not an acute safety risk (suicide, aggression)
- Patient has a full-service primary care provider and is not being referred from a walk-in clinic
- Has not had a psychiatric consultation or care within the past 6-months
- Patient is NOT being referred for the purpose of disability claims or medicolegal proceedings
- Relevant EMR notes, previous consults, and hospital discharge summaries attached
- Patient is willing to be seen via Secure DOBC Zoom for Healthcare
- Patient is willing to attend group medical visits for post-consultation psychiatric care

Referring physician information

Name: _____ MSP Number: _____

Office Address: _____

Office Phone: _____ Office Fax: _____

Patient information

First Name: _____ Last Name: _____

MSP: _____ Date of Birth: _____

Assigned Sex at Birth: _____ Gender: _____ Pronouns: _____

Phone: _____ Email: _____

Address: _____

Medical information

Reason for Referral: _____

Psychiatric Diagnosis: _____



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Aggressive Behaviour? Yes No If answering yes, please describe behavior(s) and whether it is current or past:

Suicidal Behaviour? Yes No If answering yes, please describe behavior(s) and whether it is current or past:

Psychotic Behaviour? Yes No If answering yes, please describe behavior(s) and whether it is current or past:

Substance Use? Yes No If answering yes, please describe behavior(s) and whether it is current or past:

Current Medications and Allergies (if any):

Has the patient had previous contact with mental health professionals including school counselors, psychologists, or social workers? Yes No If answering yes,

Please list the professionals and whether there is ongoing contact:

Please attach records or if unavailable, please clarify whether efforts have been made by your office to obtain:

Attach relevant information such as EMR notes, previous consults, and hospital discharge summaries.

PLEASE FAX COMPLETED FORM, QUESTIONNAIRE, AND ANY ATTACHMENTS

TO MDABC AT 1-866-821-5992