SAULT AREA HOSPITAL
HÔPITAL DE SAULT-SAINTE-MARIE

DEMOGRAPHIC LABEL

Sault Area Hospital Mental Health and Addictions Services
Outpatient Psychiatric Consultation Clinic Referral Form

The consultation process functions within a shared-care model and will involve meeting with a psychiatrist. Recommendations for care will be provided to the patient and the referring primary care provider.

By submitting this referral, I confirm that the referral is not being made solely for legal, insurance, or worker's compensation purposes and acknowledge that care will be provided using the shared-care model.

Identifying Information for Referral: **Age Requirement: 18-64 years old**

Last Name: _____ **First Name:** _____

DOB: _____ **OHIP #:** _____

Address: _____

Phone #: _____ **Parent/Guardian:** _____

Notes about who to contact: _____

Is the person aware of this referral? ☐ No ☐ Yes

Previous psychiatric consultation? ☐ No ☐ Yes **With whom:** _____

Safety concerns (i.e. violence)? ☐ No ☐ Yes Please specify: _____

Preliminary Concerns (check all that apply): ☐ **Moderate** ☐ **Severe**

☐ Mood Disorders ☐ OCD or related disorder ☐ Substance Use Disorders

☐ Anxiety Disorders ☐ PTSD ☐ Psychotic Disorders

☐ Eating Disorders ☐ Developmental Disorders ☐ Other (please specify: _____)

Reason for Referral: Please attach referral letter/summary and all relevant notes

☐ Diagnosis Recommendations for: ☐ Psychopharmacology ☐Treatment Plan ☐ 2nd Opinion

Comments: _____

Please attach the following: ***Blood work to be Completed within 1 year***

☐ Complete Blood Count ☐ HbA1C ☐ Liver Function Tests

☐ Thyroid Function Test ☐ Vitamin B12 level ☐ Lipid Profile ☐ Renal Function Test

Referring Primary Care Provider: _____ **Billing Number:** _____

Contact # _____ **Date of Referral:** _____

Please fax referrals to: 705-256-3494 **For referral status, call: 705-759-3434 ext. 4615**