HÔTEL-DIEU
ESTD GRACE 1888
HEALTHCARE

TRANSITIONAL YOUTH PSYCHIATRY CLINIC REFERRAL

COMMUNITY MENTAL HEALTH
MENTAL HEALTH OUTPATIENT DEPARTMENT

1453 Prince Road
Phone: 519-257-5111 Ext 72670
Fax: 519-973-1989

Last Name:_____

First Name:_____

D.O.B.:

Telephone:_____

Health Card #: _____VC_____

Date:_____(MM/DD/YYYY)_____

Referring Provider:_____Phone:_____Fax: _____

***Please include most recent assessment or initial assessment by Child Psychiatrists.

Current Diagnosis: _____

Current Treatment: _____

History of the Problem: _____

Previous Psychiatric Consultation/Treatment (date of most recent): _____

Past Medical History (operations, medical admissions, head injuries, seizures etc): _____

All Current Medications: _____

Substance Use: _____

Any Other Relevant Information: _____

_____ _____
Signature Printed Name of Provider

FAX COMPLETED FORM TO: 519-973-1989

_____ _____
Date (MM/DD/YYYY) OHIP Billing Number