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

Telemedicine Referral Form

Please complete and Fax to
613-774-7206 ✓
Include a consult letter

PATIENT INFORMATION			
Surname		Given Names	
Date of Birth (DD/MM/YY)		Sex ☐ Male ☐ Female	
Maiden Name		Other Name	
Address City Province Postal Code		Language ☐ English ☐ French ☐ Other: Home Phone 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 Practitioner ☐ Other:		
Name Address		Phone No. 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 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 & ongoing care to the client.			
Signature		Date (DD/MM/YY)	