

## Patient Information

Name:		OHIP #:		VC:	
Address:		Date of Birth:			
Telephone # 1:		City:		Postal Code:	
Telephone # 2:		Gender:		Marital Status:	
Language: <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other (specify):					
Living arrangements: <input type="checkbox"/> Alone <input type="checkbox"/> Spouse <input type="checkbox"/> Other Relative <input type="checkbox"/> Friends <input type="checkbox"/> Residential <input type="checkbox"/> Other					

## Contact Person

Name:		Relationship:			
Address:		City:		Postal Code:	
Telephone #:		Telephone #:			

### Contact Person to arrange appointment:

<input type="checkbox"/> Patient		<input type="checkbox"/> Referring Physician			
<input type="checkbox"/> Other Name:					
Telephone:			Relationship:		

### Referring Physician / Source

### Family Physician (if different from referring physician)

Name:		Name:			
Address:		Address:			
Telephone #:		Telephone #:			
Fax #:		Fax #:			

Is the family physician agreeable with the referral?		<input type="checkbox"/> Yes		<input type="checkbox"/> No	
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## Reason For Referral

Name:

DOB:

### Previous Psychiatric Services

- Geriatric Psychiatry Community Services of Ottawa (GPCSO)
- The Royal
- Known to psychiatrist name: \_\_\_\_\_

### Medical History

### List of all Current Medications (Please attach)

### Supporting Medical Information (Please attach)

ie: Blood work, CT Scans, X-Ray reports, medications tried, admission/discharge from hospital, consults by geriatric medicine, neurology, psychiatry or other related specialties

### Additional Information

(ie: any safety, community health, legal concerns etc. )

Incomplete information may result in a delay in the processing of this referral

### THIS SECTION IS MANDATORY FOR ALL REFERRALS

*Signature of Attending Physician/NP:*

*Attending Physician/NPBilling #:*

*Printed Name of Attending Physician/NP:*

**Please FAX To 613-562-0259**

**Tel: 613-562-9777**

Revised December 2025