Hôpital Régional de Pembroke Regional Hospital

Outpatient Psychiatry
Referral Form

Complete and fax to 613-732-6350
Note: Patient must be 17 years of age or older

PATIENT INFORMATION		
Surname	Given Names	
Date of Birth (YYYY/MMM/DD)	Gender	
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 (YYYY/MMM/DD)

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
Family Doctor (please print):
Allergies

COMPLETED BY	
Signature	Date (YYYY/MMM/DD)
* Print Name	