Centre de santé mentale
Royal Ottawa
Mental Health Centre

Telemedicine Referral Form

Complete and fax to 613-732-6350

Hôpital Régional de Pembroke Regional Hospital

Note: Patient has not been seen by psychiatrist within last 12 months

PATIENT INFORMATION

Surname	Given Names
Date of Birth (DD/MM/YY)	Sex ☐ Male ☐ Female
Maiden Name	Other Name
Address	
City	Language ☐ English ☐ French ☐ Other:
Province	
Postal Code	Home Phone
Marital Status ☐ Common Law ☐ Divorced ☐ Married ☐ Separated ☐ Single ☐ Widowed ☐ Other:	Other Phone
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)

Revised: January 2017