A Mount Sinai Hospital community program
in partnership with
Hong Fook Mental Health Association
Yee Hong Centre for Geriatric Care

3833Midland Avenue
Scarborough, ON. M1V 5L6
Tel : (416)291-3883
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REFERRAL FORM FOR FAMILY PHYSICIAN

Name of Referring M.D.:	**Physician's Billing no.:**
Address:	**Tel. no.** **Fax no.**

Patient's Information

Name:	**Gender: M / F**
Health Card no.:	**Date of Birth (YY/MM/DD):**
Address:	**Telephone no(s):**
Language (Dialect):	
Emergency Contact: **Name:**	**Tel. no.:**

Reason(s) for Referral:

□ Psychiatric Assessment	□ Diagnostic Clarification
□ Medication Consultation	□ Short-term Intervention/Counselling

Brief Description of Present Mental Health Difficulties or Other Psycho-social Problems

Brief Medical History (incl. medical conditions, surgeries, hospitalization, etc.)

Brief Psychiatric History (if applicable, incl. hospitalization, medications, previous psychiatrists, etc.)

Current Medications and/or Treatment

Allergies

Immediate Risks or Concerns (e.g. aggression, self-harm, addiction)

Signature of Referring M.D.:_____ **Date:**_____