MOUNT SINAI HOSPITAL
Joseph and Wolf Lebovic Health Complex

# REFERRAL FORM
# GERIATRIC PSYCHIATRY PROGRAMME

60 Murray Street – Suite L1-012, Toronto ON M5T 3L9 T: 416-586-4800 ext. 5192 F: 416-586-3231

*Referring Physician*

*Name of Referring Physician:* .....

*Physician's Billing Number and Specialty:* .....

*Telephone Number:* .....

*"Back line" (unlisted) Number:* .....

*Fax Number:* .....

*Address:* .....

*E-mail Address:* .....

*Signature and Date:* .....

**Patient**

Patient's Name: ..... DOB (Y/M/D): .....

❍ Male ❍ Female HIN (& Version Code): .....

Address: .....

Telephone Number: .....

Able to speak English? ❍ Yes ❍ No *If "No", language(s) spoken:* .....

Should the patient be contacted directly with an appointment? ❍ Yes ❍ No *If "No", name and telephone number of a contact person:* .....

Clinical Problem: .....

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Expectation of the Referring Physician (eg. clarification of diagnosis, ongoing treatment, etc.):

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❍ **Urgent** ❍ **Non-Urgent**

**NB. Please attach details of the patient's medical, psychiatric and medication history, relevant consultations and discharge summaries, laboratory results, and radiology/imaging reports.** *Please note that if we require further information, we will call the referring physician to discuss the referral before confirming our involvement or making the appointment. For this reason, we would appreciate the number of your "back line" (unlisted number), in order to facilitate our contact with the referring physician before and after the appointment.*

**Please fax this completed form to 416-586-3231**

**For further information please contact Anne-Marie Vico at 416-586-4800 ext. 5192**