ST. MICHAEL'S HOSPITAL MEDICAL PSYCHIATRY - Referral Form

- **Please ensure that ALL RELEVANT information are completed or PROCESSING MAY BE DELAYED.**
- **Attach most recent clinical notes and lab results if referring from outside St. Michael's Hospital**
- **If your patient requires an urgent assessment, please utilize existing emergency services**
- **Fax completed intake form to: (416) 864-5480**
- **We will contact you and your patient with appointment date and time**

Please indicate type of referral and/or the physician to whom you are referring:

☐ **Medical Psychiatry** ***(Complete pages one and two)***
- ☐ Dr. Kien Dang
- ☐ Dr. Shree Bhalerao

☐ **HIV Psychiatry** ***(Complete pages one, two and three)***
- ☐ Dr. Adriana Carvalhal
- ☐ Dr. Julie Maggi
- ☐ Dr. Mark Halman

☐ **Geriatric Psychiatry (*Complete pages one, two and four)***
- ☐ Dr. Corinne Fischer

☐ **Neuropsychiatry and Brain Injury** ***(Complete pages one, two and five)***
- ☐ Dr. Shree Bhalerao

SECTION A: PATIENT INFORMATION

Name: _____Sex:_____Date of Birth: _____

Address: _____

Telephone: Home _____ Work _____

Health Card Number: _____ St. Michael's J#:_____
(if applicable)

Family Doctor: _____

SECTION B: REFERRAL SOURCE INFORMATION

Referring Physician: _____
_

Referring Physician OHIP Registration # _____

Referring Service: _____

Telephone #: _____ Fax #: _____

Referral Date: _____

SECTION C: CLINICAL INFORMATION

1. Outcome expectation: (check all applicable)

- ☐ consultation - diagnostic/treatment plan
- ☐ consultation - neuropsychiatric assessment for possible dementia
- ☐ consultation - psychopharmacology
- ☐ Other *(specify)*_____

2. Please provide narrative for the reason of the referral and current psychiatric presentation (please be specific regarding signs/symptoms):

3. Medical Conditions:

	Problems/Issues	**Please Specify**
	Neurological /Head Injury	
	Cardiovascular	
	Respiratory/ Sleep	
	Gastrointestinal	
	Genitourinary	
	Endocrine	
	Cancer	
	Chronic pain/unexplained symptoms	
	Diabetes	
	HIV	
	Autoimmune disease	
	Issues related to organ transplant	

4. Please list all medications that patient is currently taking or attach medication list:

5. Previous history of psychiatric treatment/admission? ☐No ☐Yes *(please specify)*

6. Please indicate on the following chart if any of the following are applicable to this referral:

Is there a history of any of the following?	**Yes**	**No**	**Please Specify:**
Developmental handicap/learning disorders			
Cognitive disorder			
Personality disorder			
Homelessness			
Substance use			
Suicide attempts			
Violent behaviour			
Other self-harm behaviour			
Legal involvement			
Care history (CAS,CCAS)			

HIV Psychiatry

1. CLINICAL INFORMATION

Clinical stage of HIV infection:
- ❑ Acute seroconversion
- ❑ Asymptomatic
- ❑ AIDS
- ❑ HIV negative
- ❑ HIV status unknown

Most recent absolute CD4 + cell count: _____

Most recent Viral Load _____

Nadir absolute CD4 + cell count: _____

Neuro-imaging: ❑ No ❑ Yes *(Specify)*_____

Current Antiretroviral therapy:

- ❑ 3TC
- ❑ Abacavir
- ❑ Combivir
- ❑ Kivexa
- ❑ Trizivir
- ❑ Tenofovir
- ❑ Truvada
- ❑ Efavirenz
- ❑ Nevirapine
- ❑ Etravirine
- ❑ Atazanavir
- ❑ Darunavir
- ❑ Ritonavir
- ❑ Kaletra
- ❑ Saquinavir
- ❑ Atripla
- ❑ Raltegravir
- ❑ Maraviroc

❑ Other
(please specify)

Previous neuropsychological testing?

❑ No

❑ Yes *specify)* _____

2. Additional Information:

Memory Disorders Clinic

Reason for Referral:

Past Medical History:

Medications:

Blood Work:

Traumatic Brain Injury

Injury Type

- ❑ MVA
- ❑ Fall
- ❑ Sports-related
- ❑ Work-related
- ❑ Other
  (Please explain)

Has the patient experienced previous head injuries with changes in functioning? ❑ Yes ❑ No

Injury Characteristics:

- ❑ LOC
- ❑ Loss of memory
- ❑ Surgery (brain)
- ❑ Surgery (other)
- ❑ Seizure activity ❑ before injury ❑ after injury _____
- ❑ Tremor ❑ before injury ❑ after injury _____

Level of Education

- ❑ Secondary school
- ❑ College
- ❑ University

Family History of memory problems/dementia ❑ Yes ❑ No

Positive CT/MRI/Xray for SPECT/PET injury ❑ Yes ❑ No

Location of Head Injury

❑ Front ❑ Side ❑ Back ❑ Internal

Post-Injury:

Has the patient experienced problems with any of the following:

Falling asleep	❑ Yes	❑ No	Staying asleep	❑ Yes	❑ No
Nightmares	❑ Yes	❑ No	Panic attacks	❑ Yes	❑ No
Phobias (fears)	❑ Yes	❑ No	Organizational skills	❑ Yes	❑ No
Impulsiveness	❑ Yes	❑ No	Harm to others	❑ Yes	❑ No
Harm to self	❑ Yes	❑ No	Depression	❑ Yes	❑ No
Anxiety	❑ Yes	❑ No	Sexual Disorder due to pain	❑ Yes	❑ No
Difficulties with orgasm	❑ Yes	❑ No	Decreased sexual desire	❑Yes	❑ No
Decreased sexual arousal	❑ Yes	❑ No			

Substance use:

Before injury	❑ Yes	❑ No
Post-injury	❑ Yes	❑ No

Alcohol abuse:

Before injury	❑ Yes	❑ No
Post-injury	❑ Yes	❑ No

GYNECOLOGY/OBSTETRICS

1. **Reason for referral**

- ☐ Pregnancy: EDD _____
- ☐ Postpartum: Delivery date: _____
- ☐ Pregnancy planning
- ☐ Premenstrual syndrome/Premenstrual Dysphoric Disorder
- ☐ Pre/post menopausal
- ☐ Other *(Specify)* _____

2. **Obstetrical History**

3. **Additional Information**