PSYCHIATRIC REFERRAL FORM FOR
Dr. R. Jay Stewart, MD, MSc, FRCPC

126 May Street South
Thunder Bay, ON P7E 1B3
Phone (807) 623-3929
Fax (807) 623-3929

PATIENT INFORMATION

Name:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Birth date (MM/DD/YYYY):	Sex: ☐ M ☐ F
Address:	Health no.:		Home phone no.: ( )	
P.O. box:	City:	Province: Select...	Postal Code:	

REFERRING PHYSICIAN (A PHYSICIAN *MUST* MAKE THE REFERRAL AND BE AVAILABLE TO PROVIDE ONGOING MEDICAL CARE. IF REGULAR PHYSICIAN IS DIFFERENT THAN ONE MAKING REFERRAL, PLEASE INDICATE AT BOTTOM OF THIS FORM WHO HAS AGREED TO PROVIDE ONGOING CARE FOR THE PATIENT)

Name:	Phone no.: ( )	Best Time to call:
Address:	Fax no.: ( )	
	E-mail:	

P.O. box:	City:	Province: Select...	Postal Code:

Urgency of Referral:

☐ Semi-Urgent * (4-8 weeks) ☐ Routine (> 8 weeks)

* reason for urgency must be discussed directly between Dr. Stewart and the referral source

Type of Consultation Requested:

☐ One time ☐ Shared Care ☐ Transferred Care

CLINICAL INFORMATION

Reason for referral / Expected outcome (ie. assessment, investigation, treatment, second opinion):

Diagnosis: ☐ Confirmed ☐ Provisional ☐ Not yet diagnosed

History of presenting complaint / examination findings / investigation results :

Past Medical History / Problem List:	
Current and recent medication (including OTC):	
Clinical Warnings (allergies, blood-born diseases, other risk factors) :	
Special Considerations / other relevant information (psychosocial, special needs, language issues) :	
☐ Copy of test results and old notes included Specifically:	_____ **Signature of Referring Physician** **Date** *** A physician MUST sign referral** **(MM/DD/YYYY)**

*** If referring physician is not providing ongoing medical care, please indicate who has agreed to take on this responsibility:**

Thank you for this consultation.