Canadian Mental Health Association
Haliburton Kawartha Pine Ridge

CMHA HKPR Psychiatry Clinic

Virtual psychiatry request: Dr. Caitlin Gregory ☐ Dr. Hoa Pham ☐

Please EMAIL the completed referral form to **OTN.clinic@cmhahkpr.ca** or FAX to **705-748-5649**.

REFERRING PRACTITIONER INFORMATION	
Name of Referring Practitioner (MD/NP): Click or tap here to enter text.	**Provincial Billing#** Click or tap here to enter text.
Phone number: Click or tap here to enter text. **Ext.** Click or tap here to enter text. **Fax:** Click or tap here to enter text.	
Medical Clinic Mailing Address: Click or tap here to enter text. **City:** Click or tap here to enter text. **Province:** Click or tap here to enter text. **Postal Code:** Click or tap here to enter text.	
Signature of Referring MD/NP (Required): Click or tap here to enter text.	**Date:** Click or tap to enter a date.
Is the Patient aware of the Referral? ☐ **Yes** ☐ **No** **Does the Patient Consent to the referral and the release of health records to the clinic:** ☐ **Yes** ☐ **No**	**Does the patient have an SDM:** ☐ **Yes** ☐ **No** **Contact information:** Click or tap here to enter text.

PATIENT INFORMATION		
First Name: Click or tap here to enter text. **Last Name:** Click or tap here to enter text.	**OHIP #:** Click or tap here to enter text. **Version Code:** Click or tap here to enter text. **Exp:** Click or tap here to enter text.	
Date of Birth: Click or tap to enter a date.	**Gender:** Click or tap here to enter text.	**Pronoun(s):** Click or tap here to enter text.
Address: Click or tap here to enter text. **City:** Click or tap here to enter text. **Province:** Click or tap here to enter text. **Postal Code:** Click or tap here to enter text.		
Permission to send mail: ☐ **Yes** ☐ **No**		
Preferred Method of Contact: ☐ **Phone call** ☐**Text** ☐**email** **Phone Number:** Click or tap here to enter text.		

Email Address: Click or tap here to enter text.

Permission to leave a message: ☐**Yes** ☐**No**

Does the patient Require an Interpreter? ☐**Yes** ☐**No** **If, yes what is the language you speak?** Click or tap here to enter text.

Does the patient have accessibility needs? ☐ **Yes** ☐ **No** **If, yes what are your needs?** Click or tap here to enter text.

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REASON FOR THE REFERRAL

WHAT IS THE PSYCHIATRIC QUESTION?

Click or tap here to enter text.

DIAGNOSIS (CHECK ALL THAT APPLY)

Please list existing mental health diagnosis(es):

Click or tap here to enter text.

SUPPORTING DOCUMENTATION/INFORMATION (please include)

☐Previous psychiatric assessment	Name of the last psychiatrist: Click or tap here to enter text.
☐Active medication list	Name of Pharmacy: Click or tap here to enter text.
☐Recent bloodwork	
☐Medical information & history	
☐Relevant psychological and/or mental health assessments	