Canadian Mental Health Association
Haliburton Kawartha Pine Ridge

OTN Psychiatry Clinic

Psychiatry Clinic - Dr. Caitlin Gregory ☐ Dr. Hoa Pham ☐

Please email or fax the completed referral form to OTN.clinic@cmhahkpr.ca or 705-748-5649.

REFERRING PRACTITIONER INFORMATION	
Name of Referring Practitioner (MD/NP):	**Provincial Billing#**
Phone number: **Ext.**	**Fax:**
Medical Clinic Mailing Address: **City:** **Province:**	**Postal Code:**
Signature of Referring MD/NP (Required):	**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:**

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

Does the patient Require an Interpreter? ☐**Yes** ☐**No** **If, yes what is the language you speak?**
Does the patient have accessibility needs? ☐ **Yes** ☐ **No** **If, yes what are your needs?**

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REASON FOR THE REFERRAL
WHAT IS THE PSYCHIATRIC QUESTION?

DIAGNOSIS (CHECK ALL THAT APPLY)
☐**Depression**
☐**Anxiety**
☐**PTSD**
☐**Bipolar**
☐**Schizophrenia**
☐**ADHD/ADD**
☐**OCD**
☐**No formal diagnosis**
☐**Other (please specify):**
Please provide information about your diagnosis or your question for the psychiatrist:

SUPPORTING DOCUMENTATION/INFORMATION (please include)	
☐Previous psychiatric assessment	Name of the last psychiatrist:
☐Active medication list	Name of Pharmacy:
☐Recent bloodwork	
☐Medical information & history	
☐Relevant psychological and/or mental health assessments	