

IMPACT RESEARCH STUDY REFERRAL ~~XXXX~~

Date of Referral: _____
 (dd/mm/yyyy)

Use last page to provide additional information

Client/Patient Information	Referring Source Information
<p>Legal Name: _____ (last name, first name)</p> <p>Preferred Name (if applicable): _____</p> <p>Date of Birth: _____ Age: _____ (dd/mm/yyyy)</p> <p>Sex/Gender: <input type="checkbox"/>Female <input type="checkbox"/>Male</p> <p>Telephone number(s) (specify home, office, cell, etc.) Tel: _____ Tel: _____</p> <p>Can confidential message be left on client/patient voicemail? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Email: _____ Address: _____</p> <p>Health Card #: _____ Version code: _____</p>	<p>Name: _____ (last name, first name)</p> <p>Check one: <input type="checkbox"/> Family Physician <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other (specify) _____</p> <p>Tel: _____ Fax: _____ Email: _____ Address: _____ _____ _____</p> <p>CPSO #: _____ Or, Medical License #: _____</p> <p>Is client/patient's current psychiatrist aware of referral (if not referred by a psychiatrist)? <input type="checkbox"/>Yes <input type="checkbox"/>No <input type="checkbox"/>Unknown <input type="checkbox"/>Does not have psychiatrist</p> <p>Name of Psychiatrist (if applicable): _____ (last name, first name)</p> <p>Does the referring source wish to receive a consultation report? <input type="checkbox"/>Yes <input type="checkbox"/>No</p>

Is client/patient (or substitute decision maker) aware of and in agreement with the referral and that he/she will be seen? (check one): Yes No (If **No**, please explain): _____

Are there any other barriers to communication and/or accessibility with this client/patient?
No Yes (please specify): _____

1. WORKING DIAGNOSIS/CLINICAL PROBLEM(S)

WORKING DIAGNOSIS (CHECK ALL THAT APPLY)	SPECIFY <u>CURRENT</u> CLINICAL PROBLEMS	RELEVANT HISTORY
Anxiety <input type="checkbox"/>	<input type="checkbox"/> Social <input type="checkbox"/> Panic <input type="checkbox"/> OCD <input type="checkbox"/> Generalized	
Bipolar <input type="checkbox"/>	<input type="checkbox"/> Mania <input type="checkbox"/> Depression <input type="checkbox"/> Mixed Episode <input type="checkbox"/> First Episode Mood with Psychosis	
Depression <input type="checkbox"/>	<input type="checkbox"/> Hallucinations <input type="checkbox"/> Delusions	
Schizophrenia / Spectrum Illness <input type="checkbox"/>	<input type="checkbox"/> Hallucinations <input type="checkbox"/> Delusions <input type="checkbox"/> First Episode Psychosis	

2. RISK ISSUES

RISK ISSUE	CHECK IF YES	IF YES: WHEN?	DETAILS
Suicide attempt/ideation			
Deliberate self-harm			
Violent behaviour			
Legal involvement			
Addictions issues			
Behavioural issues			

3. CURRENT MEDICATIONS (Psychiatric) *attach additional information if needed*

MEDICATION	DOSE / FREQUENCY	RESPONSE & ADVERSE EFFECTS

4. PAST MEDICATIONS (Psychiatric)

MEDICATION	DOSE / DURATION	RESPONSE & ADVERSE EFFECTS

5. PAST PSYCHIATRIC/ADDICTIONS HOSPITALIZATIONS (attach discharge summaries)

FACILITY	DATES (dd/mm/yyyy)	REASON

6. RELEVANT MEDICAL HISTORY (e.g. endocrine, neurological, respiratory, cardiac, or other issues)

7. METABOLIC ISSUES

ADDITIONAL INFORMATION

(e.g. client/patient strengths, current and/or past medications; additional medical history; other comments)

Completed by:

_____ (print name and credentials)

_____ (signature)

Date: _____ (dd/mm/yyyy)

8. PROPOSED TREATMENT (FOR REFERRING CLINICIAN TO COMPLETE):

Imagine that you had not ordered pharmacogenetic testing for this patient. How would you have proceeded with their treatment (e.g. maintain current therapy, augment, switch, titrate off, initiate psychotherapy, etc.)? If additional medications, which medication and why?

Completed by:

_____ (print name and credentials)

_____ (signature)

Date: _____ (dd/mm/yyyy)