Canadian Mental Health Association
Cochrane-Timiskaming
Association canadienne pour la santé mentale
Cochrane-Timiskaming

330 Second Avenue, Suite 201
Timmins, Ontario
P4N 8A4

Seniors' Mental Health Program

Fax: 705-567-5211

Family Physician Agreement for Psychiatric Consultation

Date: _____

Dear: _____

Your patient: _____

D.O.B.: _____

was recently referred to the Seniors' Mental Health Program for:

_____

_____

We request your agreement before our Geriatric Psychiatrist Consultant sees your patient. Please signify your agreement by signing below and faxing the form back to us. A consultation report will be sent to you to help you in your ongoing management of your patient's care.

Are there specific areas/questions you would like us to address?

____ Clarification of diagnosis
____ Suggestions for medication or other treatment options
____ Medication review
____ Other areas or questions

Please explain: _____

_____

_____

I agree to an assessment of the above named patient by a Geriatric Psychiatrist Consultant through the Seniors' Mental Health Program.

Physician's signature: _____

Should you have any questions or concerns, please do not hesitate to contact us. Thank you for your cooperation.

Sincerely,

_____

Seniors' Mental Health Program
(w) 705-567-9596 ext. 4260
(f) 705-567-5211