Temiskaming Hospital

Psychiatry Referral Form

421 Shepherdson Road
New Liskeard, ON P0J 1P0
Fax: (705)647-8127 **Attention: Central Booking**

Dear Dr.: _____ Date: _____

RE: Name: _____

DOB: _____ **OHIP#:** _____

Phone#: day _____ **evening** _____

I would appreciate you seeing this patient in consultation. Please forward an appointment directly to my office.

Reason for referral: _____

_____

_____

Previous significant history: _____

_____

_____

Current/Past medical history: _____

_____

_____

_____

Present medications include: _____

_____

_____

Community Agency/Counsellor Involved? _____

Contacted Community Agency: _____ on _____
(name of agency) *(date)*

Sincerely, _____
Signature ***(please print - last name only)***

PRIORITY RATING: (please circle one of the following)
1) non-urgent **2)** semi-urgent **3)** urgent