Baycrest
Enriching Care
Enhancing Knowledge
Enlightening Minds

BAYCREST GERIATRIC PSYCHIATRY COMMUNITY SERVICE

Medical Referral form required prior to initial assessment. Fax to: 416-785-2492. Thank you.

PATIENT INFORMATION: **DATE:** _____

Name: _____ Date of birth: _____/_____/_____ Sex: _____
D M Y

IMPORTANT: Please confirm that patient (or family) is aware of referral ❑

Health Card # and Version Code:_____ Marital Status: _____

Address: _____ Phone: _____

FAMILY INFORMATION:

Name: _____ Relationship:_____

Phone: (H) _____ (B) _____(C) _____

REFERRING MD: Name: _____ Physician Number: _____

Phone: _____ Fax: _____

Reason for Referral: _____
_____
_____
_____

Medical History: _____
_____
_____
_____

Recent investigations: (e.g. lab ❑, CT ❑, EEG ❑ CONSULTATIONS: (e.g. neurology❑, psychiatry❑, medicine❑). Please enclose copies of relevant reports. _____
_____

Medications (please provide doses): _____
_____
_____

Previous Psychotropic Medications and Response: _____
_____

Allergies: _____

Any safety concerns for staff: (e.g. aggressive/threatening behaviour ❑, sexually inappropriate behaviour ❑, hazards in the home including pets ❑, others in the home ❑, communicable diseases ❑, smoking ❑

Additional Comments: _____
_____
_____

THANK YOU.