MOUNT SINAI HOSPITAL

Joseph and Wolf Lebovic Health Complex

Clinic for HIV-Related Concerns

Department of Psychiatry
600 University Avenue, Room 963, Toronto ON M5G 1X5
Tel: 416-586-4800 x 8714 Fax: 416-586-5970

Referral Form for Assessment

To facilitate prompt and appropriate triage, please complete all portions of this form and fax/mail it to the address above. **Incomplete or illegible forms will be returned.** The patient will be notified of their appointment time by the clinic secretary.

Date of Referral:

Patient Information:

Last Name: **First Name:**

Date of Birth: **Gender:**

Address:

Telephone: Home - Business - Cell -

OHIP Number and **Version Code:**

Previous Mount Sinai Contact:

Interpreter Service Required: ☐ No
☐ Yes Language: _____

Referring Physician:

Name: **Specialty:**

Address:

Telephone: **Fax:**

Email: **OHIP Billing #:**

Reason for Referral:

Personal History/Diagnosis:

Current Medications and Doses (Include HIV, psychiatric and other medications):

Previous Psychiatric Medications:

Most Recent CD4 Count & Viral Load: Date of Test:

Other Medical History:

Current Alcohol/Substance Use (Please specify and quantify):

Suicidality (Please specify any current concerns or past attempts):

Other Treating Mental Health Professionals:
Name: Are they aware of the referral?

Is this referral being made for Medicolegal or Insurance purposes?
(Please be aware of the fact that insurance forms can be filled out only in the context of an ongoing working relationship and there is a fee for such documentation.)
If yes, please explain:

Other comments, concerns or descriptions of the patient's situation are welcome: