KINGSBRIDGE MEDICAL CENTRE

DR. JETINDER GILL
PSYCHIATRY REFERRAL FORM

(Incomplete referrals will be returned)

FAX: 905 890 7102

Referral Date:

Appropriate psychiatric services determined by our in-house psychiatrist after initial assessment.

INCLUSION CRITERIA	EXCLUSION CRITERIA
• resides in Ontario • query mental illness	• actively suicidal or homicidal or other psychiatric emergencies • requiring crisis assessment or hospital admission • assessments for court purposes or forensic psychiatry • completion of forms for insurance or medical purposes • transfer of care from other psychiatrists or other physicians

PATIENT INFORMATION

Last Name:		First Name:	
Address:	City:	Prov:	Postal Code:
DOB (dd/mm/yyyy):	Age:	Gender: ☐ Male ☐ Female ☐ Other	
Contact Phone#:	Patient Consent to leave voicemail message? ☐ Yes ☐ No		
Email:	Patient Consent to email? ☐ Yes ☐ No		
Health Card #: VC: Exp Date:		No OHIP: ☐	
Person to contact for booking appt (if different than patient):			
Relationship to patient:			
If the patient is a child, who has parental custody/guardianship?			

REASON FOR REFERRAL

Reason for referral:

Other pertinent clinical information (attach relevant documents if available, e.g. previous consultations, discharge summaries, etc):

REFERRING PHYSICIAN / NURSE PRACTITIONER (NP) INFORMATION

*(*note referral source remains most responsible practitioner for coordinating patient's ongoing care*)*

Referring Physician/NP Name: Referring Physician/NP Signature:		OHIP Billing #:
Phone#:	Fax #:	Email:
Family Physician/NP Name: (if different from above):		

Draft Version: April 7, 2021