# Psychiatric Consultation Form

MHR# _____ 

Patient _____ Instructions: **1**.Use Ink & press firmly. **2**. Use an X to indicate your choice(s).

DOB ___ (DD) ___ (MM) _____ (YYYY) HIN _____ _____ Gender ☐ M ☐ F

Family Physician _____ Psychiatrist _____

Patient Currently Seeing HSO Counsellor ☐ Yes ☐ No

Has Patient Previously Been Seen by Non HSO Mental Health Service/Psychiatrist ☐ Yes ☐ No

Date of Consultation ___ (DD) ___ (MM) _____ (YYYY)

Referral Initiated By: ☐ Family Physician ☐ Other Primary Care Provider ☐ Family ☐ Patient ☐ HSO Counsellor ☐ Other Mental Heath Service ☐ Agency

Was Patient discharged in the last 6 months? ☐ Out-Patient Psychiatric Service ☐ In-Patient Psychiatric Service ☐ EPT

## Reason for Consultation (X all that apply)

☐ Clarification/Confirmation of Diagnosis ☐ Legal or Insurance Assessment/Documentation

**Advice Regarding :**

☐ Management ☐ Risk to Self/Others ☐ Family/Marital Problems ☐ Medication ☐ Community Resources ☐ Psychotherapy

Instructions: **1**. **X** the appropriate box(es) relevant to this episode of care.
**2**. Place an **X** on the line next to the **Problem Most Responsible for this Referral**

## Psychiatric Symptoms

☐ Depressed Mood ___
☐ Elevated Mood ___
☐ Fluctuating Mood (Mood Swings) ___
☐ Suicidal Thoughts/ Actions/ Behaviour ___
☐ Obsessive Thoughts ___
☐ Compulsive Behaviour ___
☐ Phobia(s) ___
☐ Panic Symptoms or Attacks ___
☐ Social Anxiety ___
☐ Other Anxiety Symptoms ___
☐ Flashbacks/Other Post-Traumatic Stress Symptoms ___
☐ Excessive Somatic Symptoms ___
☐ Sleep Disturbance ___
☐ Delusions ___
☐ Paranoia ___
☐ Hallucinations ___
☐ Disorganized Thought Processes ___
☐ Memory Impairment/Concentration ___
☐ Confusion ___
☐ Attention Deficit/Hyperactivity ___
☐ Personality Problems ___
☐ Unusual Behaviour ___
☐ Alcohol Abuse in Self ___
☐ Other Substance Abuse in Self ___
☐ Gambling ___
☐ Abnormal Eating Behaviours ___
☐ Learning Disability ___
☐ Developmental Delay (MR) ___

## Psychosocial Issues

☐ Marital/Common-Law /Partner Problem ___
☐ Separation/Divorce ___
☐ Other Relationship Issues ___
☐ Sexual Problem ___
☐ Self Esteem ___
☐ Anger/Temper Control ___
☐ Bereavement ___
☐ Parenting Issues ___
☐ Child Behaviour Problem ___
☐ Other Family Problems ___
☐ Illness in Family Member ___
☐ Burden of Caring for Another ___
☐ Menopause - Related Issues ___
☐ Pre-Menstrual Symptoms ___
☐ Pregnancy-Related Issues ___
☐ Alcohol Abuse in Family Member ___
☐ Past Alcohol Abuse in Self ___
☐ Past Substance Abuse in Self ___
☐ Lack of Social Supports/Social Isolation ___
☐ Physical/Sexual Abuse During Childhood ___
☐ Past Physical/Sexual Abuse (Victim) ___
☐ Current Physical/Sexual Abuse (Partner) ___
☐ Emotional/Verbal Abuse ___
☐ Other Current Abuse ___
☐ School Problems ___
☐ Work Problems ___
☐ Motor Vehicle Accident Issues ___
☐ Accommodation ___
☐ Unemployment ___
☐ Financial Issues ___
☐ Legal Issues ___
☐ Other Stressful Events ___
☐ Insurance Form/Letter to be Prepared ___
☐ Legal Letter/Report to be Prepared ___
☐ WSIB Issue ___
☐ Needs Instrumental Assistance ___

## Medical / Physical Issues

☐ Chronic Pain ___
☐ Medication Side Effects ___
☐ Physical Symptoms Other Than Chronic Pain ___
☐ Significant Medical/Physical Illness ___ _____
☐ Difficulty Coping with Physical Illness ___