Dr. Fernando & Associates
Dr. N. Fernando M.D. FRCP (C) (Psychiatry)
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SERVICE REQUEST (Choose ONE)
☐ Psychiatric Consultation
- ☐ Diagnostic Clarification
- ☐ Medication Review
- ☐ Continuity of Care (Must have been seen by Dr. N. Fernando in the last 6 months)

☐ URGENT ☐ ROUTINE

We are NOT able to accept referrals for Psychiatric treatments follow up where concerns are primarily related to:

- Anger Management
- Autism Spectrum Disorder /Developmental Delay
- Chronic Pain
- Acquired Brain Injuries
- Eating Disorders
- Primary Substance Abuse
- Relationship Counselling
- ODSP Application
- Dementia

We do not provide assessments for Legal, Insurance, Custody, CAS, WSIB or Forensic reasons.
Does your patient currently have a psychiatrist? ☐ YES ☐ NO ☐ Unknown

CLIENT INFORMATION:		
Date patient was last seen: _____Is patient agreeable to referral? ☐ YES ☐ NO		
Patient Name: Last, First	**Preferred Name:**	**Date of Birth:** YYYY/MM/DD
Address:		
Sex on Health Card: ☐ MALE ☐ FEMALE ☐ OTHER	**Gender:** ☐ MALE ☐ FEMALE ☐ OTHER	
Health Card Number:	**Version Code:**	
Home #:	**Consent to leave a message?** ☐ YES ☐ NO	
Cell #:	**Consent to text this number?** ☐ YES ☐ NO	
Email Address of primary contact for referral (required)_____ **Please ensure your patient is aware to regularly check their "Junk" box as often email servers filter emails to "Junk" due to their settings**		

EMERGENCY CONTACT: Name, Relation to client, Contact Number

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Common-law

Income (Current):
☐ Employment ☐ Social Assistance (OW) ☐ ODSP ☐ Employment Insurance
☐ Family ☐ No source of Income ☐ Pension ☐ CPP
☐ Other _____

REFERRAL SOURCE INFORMATION: Referrals **MUST** be made by a physician

Referred by: ☐ Family Physician ☐ Psychiatrist ☐ Other _____
Referring Physician's Name: _____ Billing No.: _____

REASON FOR REFERRAL

Details of Referral (including target symptoms and goals of treatment):

1. **Reason(s) for requesting this consultation:** What **specific question(s)** do you want answered? What is your **goal for this assessment?** Please specify signs/symptoms and provide examples of current changes.

2. **Diagnosis (if known):**

Current Psychiatry Medications:	Past Medications/Side Effects/ Reason for discontinuation

Must be completed:
☐ No Known Allergies ☐ Allergies: _____

Factors contributing to current referral:

☐ appetite changes ↑ or ↓ ☐ decrease in self care ☐ ADL assessment completed	☐ depressed mood / sad for more than two weeks Triggers: _____	☐ Alcohol / Drug Use (ongoing) ☐ racing thoughts
☐ cognitive changes ☐ iADL assessment completed	☐ sleep changes ↑ or ↓ ☐ sleep study ordered	☐ psychomotor retardation or agitation ☐ Tox. Screen completed
☐ compulsive behaviours ☐ examples: _____	☐ social withdrawal ☐ panic attacks ☐ significant anxiety/fears	☐ delusions ☐ examples: _____
☐ decreased energy ☐ TSH, CBC & ___ labs completed	☐ disordered thoughts and/or speech ☐ hallucinations ☐ auditory ☐ visual ☐ other	

RISKS:			
☐ Threat to self	☐ Threat to others	☐ Suicidal Ideations/ Plan/Intent /Attempts	☐ Violent Behaviour
Please Explain:			

AGENCIES, HOSPITALS OR THERAPIES INVOLVED WITHIN THE PAST TWO YEARS:

Please list all known psychiatric hospitalizations in the last five years; List all known crisis or emergency contacts over the past year:
Be sure to attach any discharge summaries, final notes, or progress notes*

Organization/Hospital	Admission & Discharge Dates	Describe Involvement / Reason for services

CURRENT MEDICAL CONDITIONS:

☐ CAD ECG Finding:_____	☐ Hyperlipidemia	☐ Diabetes Last Hgb A1C _____
☐ Seizure Disorder ☐ EtOH Withdrawal ☐ EEG ☐ Last Seizure Medications and Levels for Seizure Disorder. Med: _____ Level: _____	☐ Neurological Condition ☐ Neurology involvement (please specify current care) ☐ CHF Last known E/F	☐ Stroke/ Head Injury Imaging ☐ Osteoarthritis/Chronic Pain ☐ Pain Management Regime _____
☐ COPD	☐ Surgeries/ Procedures	☐ HTN Last B.P. _____
☐ OTHER		
List all medications for any of the indicated medical conditions above:		

Neuroimaging Completed (i.e. CT, MRI, SPECT)	**Neurocognitive Testing Completed (MoCA, MMSE etc:**

SUBTANCE USE:

Please check all that apply and underline predominant substance of concern:

Required Documentation to be attached:
☐ **ASSESSMENTS COMPLETED** (psychiatry, psychology, occupational therapy, social work etc.)
☐ **RECENT PROGRESS NOTES (**from past two weeks, any discipline)
☐ **ER/CRISIS SERVICE NOTES**
☐ **MAR**
☐ **MOST RECENT PHSYICAL SCREENING, LABWORK, & ASSOCIATED RESULTS/REPORTS**
☐ **OTHER RELEVANT INFORMATION** Please specify: _____

INCOMPLETE REFERRALS WILL BE RETURNED