The Royal
Mental Health - Care & Research
Santé mentale - Soins et recherche

PROMPT CLINIC
REFERRAL FORM

Date of Referral: DD / MM / YY

PATIENT INFORMATION

Client Name: _____ Client OHIP #: _____

DOB: DD / MM / YYYY Gender: _____ Occupation: _____

Client Address: _____ Client phone #: _____

Language(s) spoken: _____ Language required for care: _____

Does your client have any accessibility needs? _____

REASON FOR REFERRAL *(Mandatory field – please be specific)*

Why are you referring the patient now?

What is your client's current clinical presentation? - *Symptoms, presenting problem, and/or recent changes in mental status.*

RISK *(Please indicate any applicable safety risks and elaborate below)*

❑ Suicidal ideation ❑ Homicidal Ideation ❑ History of verbal/ physical aggression ❑ Falls ❑ Self-neglect ❑ Self-harm

PSYCHIATRIC HISTORY

Psychiatric Diagnosis *(suspected or known)*: _____

Date of last psychiatric assessment, if applicable: DD / MM / YYYY

Date of last psychiatric hospitalization, if applicable: DD / MM / YYYY

MEDICAL INFORMATION

Medications - *Please clearly indicate all current and/or past medications; attach a separate sheet if more space is required. If your client has no current or past medications, please indicate this below.* ***(Mandatory field – referrals will not be processed without this information)***

Current Medications	Dose	Frequency	Date started

Past Psychiatric Medications	Dose	Frequency	Date started and discontinued

The Le Royal

PROMPT CLINIC REFERRAL FORM

MEDICAL HISTORY

Allergies: _____

Pharmacy: _____ **Pharmacy Phone or Fax #:** _____

SUBSTANCE USE

❑ Yes ❑ No

SUBSTANCE	AMOUNT	FREQUENCY	LENGTH OF USE (days, months, years)	CURRENT USE Y/N (if not current, please indicate of last known usage)
Alcohol				
Cannabis				
Opioids				
Stimulants				
Hallucinogens				
Other *(specify)*:				

COMMUNITY SUPPORTS *(Please indicate full name and contact information)*

Community Agency / Case Manager	
SDM	
Other Mental Health Supports *Psychiatrist, Psychologist, Social Worker, etc.*	

REFERRAL SOURCE INFORMATION *(Mandatory field)*

Will you continue to follow this patient and provide ongoing care once discharged from our program? ❑ Yes ❑ No

Referral Source Name: _____

❑ General Practitioner CPSO #: _____ OHIP Billing #: _____

❑ Locum – *please indicate the full name, contact information, and clinic name/address of the client's ongoing provider below*

❑ Nurse Practitioner CNO #: _____ OHIP Billing #: _____

Referral Source Phone #: _____ Referral Source Fax #: _____

Referrer Signature: _____

Please fax your completed referral to Prompt Care Clinic at 613-798-2976

Questions? Please feel free to contact us at 613-722-6521 x 6300.

PLEASE NOTE:

The Prompt Care Clinic is a psychiatric consult service and does not provide ongoing follow up, or emergency/acute care intervention. If your client is in crisis, please direct them to present to their nearest emergency department.