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

Telemedicine Referral Form
Complete and fax to 1-613-725-0446

uOttawa

STUDENT INFORMATION	
Surname	Given Names
Date of Birth (YYYY/MM/DD)	Sex: Female ☐ Male ☐ Other ☐
Preferred Name	Maiden Name
Address	Language: French ☐ English ☐ Other ☐
City	Phone
Province	E-mail
Postal Code	Marital Status
Health Card Number	Version Expiry Date
EXCLUSION CRITERIA	
Does student have a current psychiatrist?	Yes ☐ No ☐
If International Student, does student have a Family Physician in Canada?	Yes ☐ No ☐ NA ☐
REFERRAL SOURCE	
Referral Source: Family Physician ☐ Nurse Practitioner ☐ Other ☐	
Name	Phone No.
Address	Fax No.
	E-mail
	Billing Number
REFERRAL DETAILS	
Type of Referral: diagnosis clarification ☐ case conceptualization ☐ treatment recommendations ☐ referral suggestions ☐	Reason for Referral:
Diagnoses (if known)	
Past Psychiatric History	Past Psychiatric Medications
Relevant Medical History	
Current Medications	
Psychiatric Hospitalizations Yes ☐ No ☐ If Yes, provide dates and reasons for hospitalization	
Allergies	
COMPLETED BY	
As Counsellor, your signature indicates commitment to provide follow-up to this patient	
Signature	Date