Integrated Psychiatry (PCN CENTRAL OFFICE)
Patient Referral Information and Psychiatric Consult Report Form
Fax to 780-481-9149

In order to provide accurate assessment and treatment plans, please complete the following information.
It is recommended a support person also attends the appointment with the patient.
Referring Physician's name:_____ Pracid number:_____

Date of referral: _____	**□ Patient agrees to referral**	**□ Ok to leave message at numbers**
(For Office Use Only)		
Appointment Date_____	Time: _____	
Patient Label: Name_____ Date of Birth_____ PHN_____ Phone (1) _____ Phone(2) _____ List past psychotropic medications that failed:	Pertinent Medical History (attach patient summary or referral letter and current medication list) Immediate psychiatric concerns /history and reason for referral:	

Psychiatrist documentation only below

General Impression:
Recommendations:

Psychiatrist Signature: _____ Date: _____