Referral package for virtual Psychiatric Emergency Assessment

Patient Demographics:

Name:
Sex:
Date of birth:
Address:
Health Card #:
Contact #:
Emergency Contact Person:
Emergency Contact #:

Email address:

Referring Site Emergency Department

We will require this completed referral package to be faxed to **613-738-4852** along with:

- Your COVID-19 Screening Documentation as per your hospital process
- Emergency Department Record: clinical notes on the patients, including the Form 1 (if there is one)

Referring physician information

Name: ________________________
Billing number: _________________
Telephone: ____________________

Date & time of the appointment: _______________________

Consultant Name

☐ Dr. Dhiraj Aggarwal	☐ Dr. Marijana Jovanovic	☐ Dr. Frederick Stocker
☐ Dr. Khalid Bazaid	☐ Dr. Rishi Kapur *	☐ Dr. Sinthuja Suntharalingam
☐ Dr. Gail Beck	☐ Dr. Erin Kelly	☐ Dr. Smita Thatte
☐ Dr. Addo Boafo	☐ Dr. Olivia Macleod *	
☐ Dr. Erinna Brown	☐ Dr. Katherine Matheson	
☐ Dr. Hélène Cadotte	☐ Dr. Robert Milin*	
☐ Dr. Michael Cheng	☐ Dr. Kathi Pager	
☐ Dr. Timothy Ehmann	☐ Dr. Lara Postl	
☐ Dr. Hazen Gandy	☐ Dr. Philippe Robaey	
☐ Dr. Clare Gray	☐ Dr. Marjorie Robb	
☐ Dr. Sophia Hrycko	☐ Dr. Clare Roscoe	
☐ Dr. Leanna Isserlin	☐ Dr. Aaron Silverman	
☐ Dr. Liisa Johnston	☐ Dr. Wendy Spettigue	

*On Leave

The Ottawa Hospital | L'Hôpital d'Ottawa — Hôpital Montfort — Queensway Carleton Hospital — CHEO — Cornwall Community Hospital / Hôpital communautaire de Cornwall — CRITICALL ONTARIO

REGIONAL MEDICAL CLEARANCE & REPATRIATION FORM

Mental Health Patients ONLY

FAX NUMBERS:

Cornwall	**613-938-5551**
Deep River & District Memorial Hospital	613-584-1599
Pembroke Regional Hospital	613-732-6351
Renfrew Victoria Hospital	613-432-5293
St. Francis Memorial Hospital	613-756-5997
TOH- PES General Campus	613-739-6149
TOH- PES Civic Campus	613-761-5270
Winchester District Memorial Hospital	613-774-6853

MD contact information Phone: ______________________

Fax:

Patient has a permanent address in Ontario? ▫ **Yes** ▫ **No**

Known history in mental health? ▫ **Yes** ▫ **No**

Is patient voluntary? ▫ **Yes** ▫ **No**

If certified, are you sending the original of the form 1? ▫ **Yes** ▫ **No**

HEALTH ASSESSMENT

1. Is the patient alert and oriented? ▫ **Yes** ▫ **No**
2. Are there any signs of psychosis? ▫ **Yes** ▫ **No**
3. 3. Any problems with violence or aggression? ▫ **Yes** ▫ **No** If YES, Please provide details:

____

Vital signs:	Blood pressure:	Heart rate:	SAT:	Temperature:

1. Abnormal physical exam *(a physical exam must be done)* ▫ **Yes** ▫ **No**
2. New physical complaint(s) ▫ **Yes** ▫ **No**
3. History of active or chronic medical illness needing evaluations ▫ **Yes** ▫ **No**
4. Evidence of intoxication or withdrawal or know history of substance abuse ▫ **Yes** ▫ **No**
5. Altered level of consciousness or fluctuating mental status ▫ **Yes** ▫ **No**
6. Suspicion of pregnancy ▫ **Yes** ▫ **No**

If yes to any of the above questions, indicate which of the investigation are required. The investigations required must be completed before the transfer. Abnormal results must be discussed with the physician who accepts the transfer.

- ▫ CBC ▫ ASA
- ▫ Electrolytes ▫ Acet.
- ▫ Urea ▫ Urine Toxicology
- ▫ Creatinine ▫ ECG
- ▫ ETOH ▫ Diagnostic imaging

Other: ______________________

Patient's medical condition is sufficiently stable for inter-hospital transfer ▫ **Yes** ▫ **No**

Treatments done in the ED & Additional Comments :

Ongoing treatments needs :

I accept that the patient is returned if necessary when the mental health of the patient is stabilized. If a patient requires a repatriation.	
Please ensure the following: Patient's belongings must accompany patient (identification, house keys and appropriate clothing for weather) **CHEO June 2020**	Physician Name (Print):_______________________________ Physician signature:__________________________________ Date:____ _ Time:____ _