Referral package for virtual Psychiatric Emergency Assessment

CHEO

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:

- 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. Ademola Adeponle	□ Dr. Marijana Jovanovic	□ Dr. Wendy Spettigue
□ Dr. Dhiraj Aggarwal	□ Dr. Rishi Kapur	□ Dr. Smita Thatte
□ Dr. Khalid Bazaid	□ Dr. Esperance Kashala	
□ Dr. Erinna Brown	□ Dr. Erin Kelly	
□ Dr. Addo Boafo	□ Dr. Olivia Macleod	
□ Dr. Hélène Cadotte	□ Dr. Marina Moharib	
□ Dr. Michael Cheng	□ Dr. Katherine Matheson	
□ Dr. Barbara Deren	□ Dr. Tea Rosic	
□ Dr. Hazen Gandy	□ Dr. Lara Postl	
□ Dr. Clare Gray	□ Dr. Philippe Robaey	
□ Dr. Sophia Hrycko	□ Dr. Marjorie Robb	
□ Dr. Leanna Isserlin	□ Dr. Clare Roscoe	
□ Dr. Liisa Johnston	□ Dr. Josh Smalley	

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:_____

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Time:_____

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