The Mood Disorders Centre Of Ottawa

REQUEST FOR CONSULTATION

Date of Request: ____________________

REFERRING PHYSICIAN'S CONTACT INFORMATION:

Physician's Name: (Please print clearly)			
Office Address:			
Tel No.:		**Fax No.:**	
Referring Physician's Billing Number:			

PATIENT'S IDENTIFYING INFORMATION:

Surname		**First Name**		**Initial**	
DOB:		**Health Insurance No.**		**Version Code**	
Number of Children:		**Current Ages:**			
Address:					
Tel No:					

MDCO-REQUEST FOR CONSULTATION

REASON FOR REFERRAL: (what question do you want answered?)

PSYCHIATRIC HISTORY:

Current Treating Psychiatrist:			**Current Physician:**		
Previously seen by a Psychiatrist (check if yes or no)	**YES:**		**Psychiatrist's Name Date/dates seen**		
	NO:				

CURRENT SYMPTOMS:

HISTORY/CLINICAL COURSE:

FAMILY HISTORY *(Please indicate with checkmark for either yes or no if psychiatric illness is documented or suspected)*:

			if yes please indicate symptoms/type of illness	treatment yes/no
Father	**Yes**			
	No			
Mother	**Yes**			
	No			
Siblings	**Yes**			
	No			
Children	**Yes**			
	No			
Other Relatives	**Yes**			
	No			

(If required, please attach additional info)

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CURRENT MEDICATIONS:

Name of Medication	Dosage	Date started Medication

PAST PSYCHOTROPIC MEDICATIONS: (If needed, please attach additional sheets)

Name Of Medication	Dosage	Duration:	Response/adverse effects

ALLERGIES: ______________________________________

MEDICAL HISTORY: (If needed, please attach additional sheets)

SUBSTANCE ABUSE: (Briefly describe substance abuse history)

PENDING COURT CHARGES: Yes _________ No ___________

IMPORTANT: Agreement required to proceed with consultation

MDCO has a screening process, and should this request for consultation be accepted, I understand that this is a specialized consultation service. There will be an assessment and treatment recommendations made. Upon completion of this consultation, as the referring physician, I am prepared to commit to following this patient, or have the agreement of Dr. _________________ to assume this patient's care.

Physician's signature ______________________ Date ______________

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