

## **Psychiatry Referral Package – Dr. Kathleen Pierson**

MRU Health Services is accepting referrals for psychiatric consultations with Dr. Kathleen Pierson. A physician referral is required.

If you think this might be a good option for you, talk to your doctor to see if a referral is appropriate. If so, your doctor will complete and submit the referral paperwork. Once it is received, you will be contacted to book your appointment.

Assessments are **by phone only** and there's no cost with a **valid Alberta Health Care card**.

For additional support, if you are affiliated with MRU you can book an appointment with our Mental Health Nurse by calling 403.440.6326 or online at [mtroyal.ca/WellnessServices](https://mtroyal.ca/WellnessServices).

### **Information for Referring Physicians:**

We are currently accepting referrals for psychiatric consultations with Dr. Pierson. Please note the following details:

- Service description: **Single-session** psychiatry assessment **by phone only**.
- Area of interest: General adult psychiatry, early psychosis, autism
- **Exclusions:**
  - Unable to accept urgent referrals
  - Does not provide ongoing care
  - Cannot see patients without a valid Alberta Health Care card
  - Does not accept individuals under age 18 or over age 65
- Referral process: Referral letters are accepted or you may use the referral form available at [mru.ca/psychiatryreferral](https://mru.ca/psychiatryreferral).

**Please fax your referral to MRU Health Services at 403-440-6759, along with relevant records, such as psychiatry consults or discharge summaries.**

Triage is based on urgency, and wait times may vary. If you have any questions or concerns, please contact us.



**Psychiatric Concerns**

**What are the psychiatric concerns?** Check all that apply.

Anger   
  Anxiety/Panic   
  Attention   
  Concerning Behavior   
  Depressive/Mood  
 Hyperactivity   
  Relationship Issues   
  Sleep Problems   
  Substance use  
 Other: \_\_\_\_\_

**Psychiatric History**

Does this patient have any **mental health diagnoses**?  Yes  No  
 If yes, provide details:

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Has your patient **previously seen a psychiatrist**\*?  Yes  No  
 If yes, provide names and dates seen:

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Describe **prior psychiatric treatments**, e.g., current & trialed medications:

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**Additional Details**

Provide any additional relevant information.

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**Completed By**

Name	Signature	Designation	Date (DD/MMM/YYYY)

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