Mount Royal University Health Services
4825 Mount Royal Gate S.W. Calgary AB T3E 6K6
Phone: 403.440.6326 | Fax: 403.440.6759

MRU Psychiatry Referral Package

MRU Health Services accepts referrals for in-house psychiatric consultations. This service is for those requiring psychiatric assessment and is not suitable for patients requiring ongoing care.

Instructions for Referring Physicians

Please fax your referral to MRU Health Services and ensure it includes the following information:

1. MRU Psychiatry Referral Form* (see attached)
2. Blood work, within the past 6 months: CBC, Electrolytes, ALT, GGT, TSH, Creatinine, Random Glucose (*Note: While it is preferred to have this included with the referral, Dr. Pierson has been accepting referrals without blood work while Covid-19 restrictions are in place.)*
3. Relevant records, e.g. psychiatry consults, discharge summaries

We will notify you by fax about the referral status.

Instructions for Patients

Take these forms to your family physician to complete. If you do not have a family physician, take the forms to the physician who currently or previously has been involved in your mental health care.

The referral must include recent blood work. Your doctor will be able to give you a lab requisition if you have not had all of the required tests completed within the past six months.

Once a referral is approved, you will be contacted to schedule an appointment. You may be booked to see our mental health nurse if there are additional questions or concerns.

Appointment Bookings

Triage occurs on an urgency basis and wait times vary. If you have any questions or concerns feel free to contact us.

Thank you,

MRU Health Services Team

***For future referrals, this form is available at MRU.ca/psychiatryreferral**

Attention: Dr. Kathleen Pierson (Psychiatry)
To: MRU Health Services
Tel: 403.440.6326 | Fax: 403.440.6759

MRU Psychiatry Referral Form

Referring Physician: If possible please include blood work within the past 6 months (CBC, creatinine, electrolytes, ALT, GGT, random glucose, TSH) and relevant assessments. Please fax the complete referral to MRU Health Services.

Referring Physician Details	**Today's Date: _____**
Name:	PRACT ID:
Clinic Name:	Address:
Phone:	Fax:
Patient Details	
First Name:	Last Name:
Address:	
Date of Birth (DD-MOS-YY):	Provincial Health Care #:
Preferred Phone #:	Can we leave a voice message? ☐ Yes ☐ No
Alternate Phone #:	Can we leave a voice message? ☐ Yes ☐ No
MRU Employee or Student? ☐ Yes ☐ No	

RISK MANAGEMENT	**What are the PSYCHIATRIC CONCERNS?**	
Is this person at risk: ☐ To themselves? ☐ To others? ☐ Not at risk?	☐ Anger	☐ Hyperactivity
Does this person have a suicidal plan? ☐ Yes ☐ No	☐ Anxious/Panic	☐ Relationship Difficulties
Does this person have psychosis symptoms? ☐ Yes ☐ No	☐ Attention	☐ Sleep Problems
Please provide details below.	☐ Concerning Behavior	☐ Substances
	☐ Depressive/Mood	☐ Other:_____

Mental Health Diagnoses

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

Triage Details e.g. current stressors, clinical features, risk factors, safety concerns, date of onset

Psychiatric History Please attach all relevant psychiatric records.

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

Describe prior psychiatric treatments e.g. current and trialed meds:

What QUESTIONS do you have for the psychiatrist? i.e. specific purpose of the referral

Fax Received: _____