

## **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
3. Relevant records, e.g. psychiatry consults, discharge summaries

**Incomplete referrals will not be accepted.** 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](https://www.mru.ca/psychiatryreferral)

## MRU Psychiatry Referral Form

**Referring Physician:** Referrals **must include** this form, 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. *Incomplete referrals will not be accepted.*

<b>Referring Physician Details</b>		<b>Today's Date:</b> _____	
Name:		PRACT ID:	
Clinic Name:		Address:	
Phone:		Fax:	
<b>Patient Details</b>			
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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
MRU Employee or Student? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>RISK MANAGEMENT</b>		<b>What are the PSYCHIATRIC CONCERNS?</b>	
<b>Is this person at risk:</b> <input type="checkbox"/> To themselves? <input type="checkbox"/> To others? <input type="checkbox"/> Not at risk?		<input type="checkbox"/> Anger <input type="checkbox"/> Anxious/Panic <input type="checkbox"/> Attention <input type="checkbox"/> Concerning Behavior <input type="checkbox"/> Depressive/Mood	
<b>Does this person have a suicidal plan?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Does this person have psychosis symptoms?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Please provide details below.		<input type="checkbox"/> Hyperactivity <input type="checkbox"/> Relationship Difficulties <input type="checkbox"/> Sleep Problems <input type="checkbox"/> Substances <input type="checkbox"/> Other: _____	
<b>Mental Health Diagnoses</b>			
Does this patient have a mental health diagnoses? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, provide details:			
<b>Triage Details</b> e.g. current stressors, clinical features, risk factors, safety concerns, date of onset			
<b>Psychiatric History</b> Please attach all relevant psychiatric records.			
Has your patient previously seen a psychiatrist? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, provide names and dates seen:			
Describe prior psychiatric treatments e.g. current and trialed meds:			
<b>What QUESTIONS do you have for the psychiatrist?</b> i.e. specific purpose of the referral			