REQUEST FOR CONSULTATION

Specialist psychiatric consultation: psychedelic-informed options

PATIENT INFORMATION

LAST NAME | FIRST NAME

DATE OF BIRTH (YYYY-MM-DD) | AGE | GENDER ○ M ○ F ○ Other

ADDRESS | CITY | PROV

PHN | OUT-OF-PROVINCE PHN ○ Yes ○ No

PHONE NUMBER | EMAIL

REQUIRES INTERPRETER ○ Yes ○ No | LANGUAGE

REFERRING PRACTITIONER & CLINIC INFORMATION

○ Family Doctor
○ Nurse Practitioner
○ Psychiatrist
○ Other (specify):

NAME | PRAC ID #

CLINIC ADDRESS

PHONE | FAX

PATIENT SCREENING INFORMATION (please complete as thoroughly as possible)

Does the patient have any of the following?	Yes	No	Don't know
a. substance use and/or alcohol use disorder	○	○	○
b. experiencing current psychotic symptoms	○	○	○
c. experiencing a current manic episode	○	○	○
d. symptomatic traumatic brain injury	○	○	○
e. known allergies, or previous intolerance, to medications used in specialist treatment	○	○	○
f. uncontrolled or insufficiently treated hypertension	○	○	○
Is there a chance that the patient could be pregnant?	○	○	○

ANY RELEVANT INFORMATION

CLINICAL HISTORY / DIAGNOSES (attach if necessary)

I support referral of this patient for specialist consultation at Manor Clinic. I have examined this patient and certify that, to the best of my knowledge, I have indicated above any medical contraindications and special instructions relevant to specialist assessment.

REFERRING PRACTITIONER'S SIGNATURE (type your name, or sign after printing) | DATE (YYYY-MM-DD)

PLEASE SEND THE COMPLETED FORM TO

Manor Clinic, 1107 127 Street SW, Edmonton, Alberta T6W 1A3

Fax: 780-666-2608 Email: admin@manorclinic.ca Questions: 780-669-8555

WE WILL CONTACT YOUR PATIENT DIRECTLY

A referral letter will also be accepted in lieu of the Manor Clinic referral form.