Reset Form

DEPARTMENT OF PSYCHOSOCIAL ONCOLOGY REFERRAL FORM

FOR URGENT REFERRALS PLEASE CALL 16-4525

610 University Avenue, Toronto, Ontario M5G 2M9

Phone: 16 4525 Fax: 16-2047

****Note: Psychosocial Oncology accepts INTERNAL referrals only**

4908

Date Sent: ______ (dd/mm/yyyy)

Referring Service: ______

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Patient Location: ◯ hdzǘǈJl-ǘʎŜyǘ ◯ Ŀnpatient Unit

Psychosocial Oncology is an integrated program that includes social work, psychology and psychiatry. Please indicate the reason for referral and we will assign to the appropriate clinician(s):

- ☐ Counseling to support coping with cancer
- ☐ Community resources needed
- ☐ Financial difficulties
- ☐ Palliative care planning
- ☐ Palliative discharge planning
- ☐ Child-related issues
- ☐ Suicidality or self harm
- ☐ Aggression or homicidality
- ☐ Psychiatric symptoms (depression, anxiety, psychosis, delirium)
- ☐ Memory or other cognitive dysfunction
- ☐ Treatment adherence or decision-making difficulties
- ☐ Psychiatric medication assessment
- ☐ Support medical team with complex patient
- ☐ Other (please explain in space provided below)

PATIENT INFORMATION

Last Name:	First Name:	Date of Birth (dd/mm/yyyy):	ａwb:
Health Card #:	Version:		
Street Address:			
City:	Province:	Postal Code:	
Phone (Home):	Phone (Cell):	Phone (Work):	
Alternate Contact Name:	Relationship:	Phone (Home/Cell):	
Referring Physician Billing Number:	Referring Physician Phone:	Referring Physician Fax:	
Family Physician Name:	Family Physician Phone:	Family Physician Fax:	

Reason for Consultation:

Diagnosis:

Does patient currently have psychiatric/mental health services in the community?

◯ Yes ◯ No

Patient informed about referral?

◯ Yes ◯ No

Interpreter Services?

◯ No

◯ Yes, Please specify language: