North Bay Regional Health Centre

Outpatient Psychiatry Clinic
Consultation Request

Date (d/m/yyyy): ___/___/_____

Name: ____ Date of Birth (d/m/yyyy): ___/___/_____

Address:____

Phone Number: _____________________________ Health Card Number: _______________________

Reason for Consultation:
Pertinent Clinical Information:
Substance Use History:
Past Psychiatric History (Please attach reports not part of NBRHC Clinical Records):
Current Medications:
Previous Medication Trials (name and maximum dosage):
Referring Primary Care Provider: _______________**Referring OHIP Number:** __________________

Outpatient Psychiatry Clinic contact information- c/o Central Intake:

Tel: 705 476-6240 ext. 6294 **Fax: 705 476-6136**