



DT9301

## ADULT PSYCHIATRIC CONSULTATION

**Note: Refer to the clinical alerts on the back of the form.  
Do not use this form for a dangerous or non-collaborating patient.**

Patient's first and last name			
Health insurance number	Year	Month	Expiry
Parent's first and last name			
Area code	Phone number	Area code	Phone number (alt.)
Address			
Postal code			

<b>Preferred language for evaluation</b>	<input type="checkbox"/> French	<input type="checkbox"/> English
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<b>Significant person able to accompany the patient to the appointment</b>	Name	Area code	Phone number
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### Step 1 – Reason for consultation

<input type="checkbox"/> Diagnostic Assessment	<input type="checkbox"/> Treatment recommendations	<input type="checkbox"/> Consultation at the adult guichet d'accès en santé mentale
<input type="checkbox"/> Access to social or psychological services	Pharmacological opinion or other brief question <b>USE TELEPHONE CONSULTATION SERVICES</b>	

### Step 2 – Clinical situation

<input type="checkbox"/> Depression: recurrent or refractory to optimised treatment <i>(Prerequisite: basic blood work, TSH, pharmacological history)</i>	<input type="checkbox"/> <b>First episode</b> psychosis or psychotic mania <i>(Prerequisite: if feasible, screen for cannabis, cocaine &amp; amphetamines)</i>
<input type="checkbox"/> Anxiety disorder: refractory to optimised treatment <i>(Prerequisite: basic blood work, TSH, pharmacological history)</i>	<input type="checkbox"/> Psychosis or mania <i>(Prerequisite: basic blood work, TSH, pharmacological history)</i>
<input type="checkbox"/> Personality disorder, refractory to psychological intervention in first-line services	<input type="checkbox"/> ADHD in adults: refractory or atypical <i>(Prerequisite: CADDRA screening questionnaire<sup>3</sup>)</i>
<input type="checkbox"/> Behavioural problems associated with cognitive decline or a mood disorder <i>(Prerequisite: MOCA<sup>2</sup>: ____ or MMSE: ____ )</i>	<input type="checkbox"/> Substance dependence associated with a psychiatric disorder (substance(s): _____ )
<input type="checkbox"/> Other:	

### Step 3 – Clinical priority based on functional impairment

<input type="checkbox"/> Important impairment or unstable disorder, with mild disorganisation and risk of deterioration if treatment is delayed	<b>B</b> (≤ 10 days)
<input type="checkbox"/> Moderate or mild functional impairment, non-responsive to usual treatment	<b>C</b> (≤ 28 days)
<input type="checkbox"/> Preserved functioning but significant distress, non-responsive to usual treatment	<b>D</b> (≤ 3 months)
<input type="checkbox"/> Chronic condition to be optimised	<b>E</b> (≤ 12 months)

<b>Suspected diagnosis and clinical information (mandatory)</b>	<b>If prerequisite is needed:</b>
	<input type="checkbox"/> Available in the QHR
	<input type="checkbox"/> Attached to this form

### Special needs:

<b>Referring physician identification and point of service</b>		<b>Stamp</b>
Referring physician's name	Licence no.	
Area code Phone no.	Extension Area code Fax no.	
Name of point of service		
<b>Signature</b>	Date (year, month, day)	
<b>Family physician:</b> <input type="checkbox"/> Same as referring physician <input type="checkbox"/> Patient with no family physician		<b>Registered referral (if required)</b>
Family physician's name		If you would like a referral for a particular physician or point of service
Name of point of service		

Patient first and last name	Health insurance number
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<b>Past Psychiatric history:</b>
<b>Current stressor(s):</b>
<b>Pharmacological history (drug, maximum dose, efficacy, side effects):</b>
<b>Previous and current psychosocial approaches (type and outcome):</b>
<b>Patient expectations</b>
<b>Substance use disorder history:</b> <input type="checkbox"/> No, <input type="checkbox"/> Yes – specify which one(s)
<b>Situation discussed with the doctor who is répondant en psychiatrie:</b> <input type="checkbox"/> No, <input type="checkbox"/> Yes
Specify with whom:
<b>Safety:</b> <input type="checkbox"/> Patient does not represent an <b>immediate</b> threat to themselves or others
<b>Consent:</b> <input type="checkbox"/> Patient verbally consents to sending the request to the GASM of their sector and agrees to proceed with the evaluation of the request
<b>Motivation:</b> <input type="checkbox"/> Motivated with active and constant collaboration <input type="checkbox"/> Ambivalent <input type="checkbox"/> Little to no motivation
<b>If not motivated, please help improve patient's motivation before referring. If deemed a threat to themselves or to others, refer patient to the emergency room. If not collaborating and deemed a threat to themselves or to others: dial 911.</b>
<b>Attach any other documents relevant to the consultation.</b>

<b>Clinical alerts (non-exhaustive list)</b>
<b>Refer the patient to the Emergency-department</b>
<ul style="list-style-type: none"> <li>• Unstable state with serious disorganisation of speech and/or behaviour</li> <li>• Delirium</li> </ul>
<b>Other resources available</b>
<ul style="list-style-type: none"> <li>i. Social info line: 811</li> <li>ii. Find your sector Crisis Center: <a href="https://www.centredecrise.ca/listecentres">https://www.centredecrise.ca/listecentres</a></li> <li>iii. Suicide Prevention Helpline: 1 866 277-3553 (appelle)</li> </ul>

<b>DO NOT use this form for:</b>
<ul style="list-style-type: none"> <li>• A patient who already has active psychiatric follow-up-refer them back to their treating psychiatrist or treating team</li> <li>• A medical-legal opinion or a parental capacity assessment</li> <li>• A patient without a mental health problem - Refer him to the general social services of your establishment instead</li> </ul>

**Legend**

- <sup>1</sup> Telephone consultation with a psychiatrist: Communicate with the specialist doctor responding in psychiatry or, failing that, with the on-call psychiatrist in order to obtain a quick answer to your question.
- <sup>2</sup> MOCA: form available at [www.mocatest.org](http://www.mocatest.org)
- <sup>3</sup> CADDRA: form available at [www.caddra.ca](http://www.caddra.ca)