SYNAPSE CLINIC
Dr. O. A. Adefolarin
MBBS, FRCpsych, FRCPC
Unit 2 - 279 Hamilton Road - Yorkton, SK S3N 4C6
Phone: 306-782-2533 | Fax: 1-855-262-5309

GENERAL PSYCHIATRY REFERRAL FORM

Patient Identification:	Referring Physician:
Name: _____	**Name:** _____
Birthdate: _____	**Address:** _____
HSN: _____	_____
Address: _____	_____
_____	**Tel:** _____
_____	**Fax:** _____
Tel: _____	**Billing Number:** _____

Preferred Assessment Service:

☐ Psychiatric Consultation ☐ Medication Management ☐ Diagnosis Clarification

TMS Consultation:

☐ Major Depressive Disorder ☐ Anxiety ☐ PTSD
☐ OCD ☐ Migraine ☐ Chronic Tinnitus
☐ Postpartum Depression ☐ Alcohol Addiction ☐ Bipolar Depression
☐ Schizophrenia Negative Symptoms ☐ Schizophrenia auditory hallucinations

Reason for Referral (Specify current symptoms, presenting problems, and history. Attach charts):

_____

_____

_____

_____

_____

☐ Suicide Attempt ☐ Deliberate Self Harm ☐ Violent Behaviour ☐ Legal Involvement ☐ Fire Setting

Current Alcohol/Substance use: _____

_____

Agencies, hospitals and therapies involved within the past two years:

Organization: *Describe Involvement:*

_____

_____

Current Medications and Doses: _____

_____

_____

_____ _____

Date of Referral Signature of Referring Physician