HÔTEL-DIEU
ESTD GRACE 1888
HEALTHCARE

W-PEP REFERRAL
Dr. Abouhassan, Dr. Villella, Dr. Montaleone
Attending Psychiatrists
1453 Prince Road, Windsor, ON N9C 3Z4
Phone: 519-257-5111 Ext 76830 Fax: 519-257-5188

Name: _____ D.O.B.: _____ (MM/DD/YYYY)

Address: _____ Phone: _____

Health Card #: _____ V.C.: _____

Emergency Contact: _____ Phone: _____

Relationship: _____ Family Doctor: _____

Reason for Referral: ☐ Schizophrenia ☐ Schizoaffective ☐ Delusional Disorder
☐ Psychosis NOS ☐ 2nd Opinion (consult only) ☐ Other _____

Please describe the problem(s)/your specific question (attach consult): _____

_____

_____

Past psychiatric history/treating physician: _____

Pertinent medical conditions/past psychiatric hospitalizations: _____

_____

Current medications: _____

_____

Impression of treatment compliance: _____

Use of drugs/substances: _____

_____

Community agencies involved in this patient's care: _____

_____

Any pending or ongoing legal issues:

_____

Referring M.D. Information: Name: _____ Physician Billing #: _____

Phone: _____ Fax: _____ Date of Referral: _____ (MM/DD/YYYY)

Please attach any past psychiatric history pertinent to the patient's care.

To be completed by W-PEP Team

Intake Nurse/Doctor:

_____

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Contact Dates:

Assessment Date: