Dr. Peter Cordell, MD, FFRCPC, Psychiatrist
65 Hanson Ave., The Family Centre, (2nd Floor)
Kitchener, ON, N2C 2H6
Phone: 519-741-1121 Fax: 226-812-0169
Website: www.sdrc.ca

PSYCHIATRIC CONSULTATION REQUEST (Physician or Nurse Practioner to Complete)

Child/Youth Information					
Name of Individual			Date of Birth (YYYY/MM/DD)		
Health Card Number		Version Code		Expiry Date	
Parent/Legal Guardian					
Name of Individual					
Contact Number			Email Address		
Home Address					
Languages Spoken			Interpreter?	☐ Yes ☐ No	

Referring Physician or Nurse Practitioner			
Name			
Address			
Fax Number		Billing Number	

SDRC Service Coordinator			
Name			
Phone Number		Email Address	

Reason for Consultation Request?

Is the parent/guardian aware of this referral and in agreement with medication review	☐ **Yes** ☐ **No**

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What is your current diagnostic understanding of this client?

Current Medications		
Medication	Dose	Date Started

Previous Medications Tried:				
Medication	Dose/How Long Was it Taken?	Year Tried	What Helped?	Side Effects?

Previous or Current Psychiatry Involvement?

Please summarize any pertinent current medical concerns and past medical history:

_____ _____

Physician Signature **Date Referral Sent**