resilience | Huron Perth Mental Health Services

CHO Referral Form
Physician to Complete This Page

Medical Report & Discharge Summary

Name of Patient _____

A. Axis I _____

B. Axis II _____

C. Axis III _____

D Axis VI _____

Systemic Conditions: (Indicate applicable item and specify below)

Seizures ☐ Dysphagia ☐ Dysarthria ☐ Aphasia ☐ Dysuria ☐ Hemorrhoids ☐
Polyuria ☐ Diabetes ☐ Dyspnea ☐ Hernia ☐ Cardiac Failure ☐ Emphysema ☐
Arthritis ☐ Neurological Deficit ☐

Remarks:

Family Physician: _____
Date of last physical examination: _____

Psychiatrist: _____
Date of last psychiatric appointment: _____

Optometrist: _____
Last Examination Date: _____

Dentist: _____
Last Examination Date: _____

Please attach current list of medications (Mar sheet)

Signature of Staff Physician: _____
Date: _____

Print Staff Physician Name: _____
Phone: _____

Please Include/ attach any pertinent information or documents.