

REFERRING PHYSICIAN

Title * Full name *

Phone * Email *

Professional address *

Requested intervention (check as appropriate)

- ECT Ketamine IV
 TMS N₂O
 Consilium Dexmedetomidine IV

Current outpatient follow-up Yes No

PATIENT

Last name * First name *

Date of birth * Phone

Email Address

DIAGNOSES

Primary and secondary diagnoses *

CURRENT CLINICAL STATUS

Depression level: Severe Moderate Mild None

Suicidality level: High Moderate Low None

Psychotic symptoms

Substance abuse

Personality disorder / significant traits

REASON FOR REFERRAL

Reason for referral (include target symptoms) *

MEDICAL PROBLEMS

Significant medical problems

Abnormal laboratory results

CURRENT PHARMACOLOGICAL TREATMENT

Current medications (with dosage) *

TREATMENT HISTORY

Previous psychiatric treatments (pharmacological, interventional)

PLANNED OUTPATIENT FOLLOW-UP

Referring physician name if different from above

Appointment frequency

The patient has given consent for this referral and the transmission of their medical data to LCIP.