

# DR. PAULINE LYSAK

P S Y C H I A T R I S T    B.Med, M.D., FRCP(C)

Tel (250) 483-7641  
Fax (250) 483-7643  
office@lysak.org  
www.lysak.org

## About the Patient

NAME	
DOB (D/M/Y)	PHN
ADDRESS	MAIN PHONE <input type="checkbox"/> HOME <input type="checkbox"/> CELL <input type="checkbox"/> WORK
	ALT PHONE <input type="checkbox"/> HOME <input type="checkbox"/> CELL <input type="checkbox"/> WORK
	EMAIL

## About You

NAME	
MSP	OFFICE PHONE
BACK LINE	FAX
ADDRESS	

Please include (here or on separate pages) all of the following:

REASON FOR REFERRAL	
CURRENT PHYSICAL, PSYCHIATRIC & SUBSTANCE USE DIAGNOSES	
ALL CURRENT MEDICATIONS & DOSES	ALLERGIES
<input type="checkbox"/> PREVIOUS PSYCHIATRY REPORTS ATTACHED                      IF REPORTS NOT AVAILABLE, SPECIFY WHO/WHERE SEEN, APPROX. DATE, REASONS <input type="checkbox"/> SEEN BY PSYCHIATRY, NO REPORTS AVAILABLE: <input type="checkbox"/> ER / PES <input type="checkbox"/> USTAT (OR SIMILAR) <input type="checkbox"/> INPATIENT <input type="checkbox"/> OUTPATIENT <input type="checkbox"/> NOT SEEN BY PSYCHIATRY BEFORE	
PREVIOUS PSYCHOTROPIC MEDICATIONS USED/TRIED	
ATTACH RECENT LABORATORY INVESTIGATIONS (INCLUDE AT LEAST THE FOLLOWING, PLUS ANY APPLICABLE MED LEVELS, E.G. VALPROATE) FERRITIN _____ VIT B12 _____ TSH _____ CREA _____ ALT _____ QTC INTERVAL _____ <input type="checkbox"/> WILL ORDER MISSING LABS	
ANY OTHER IMPORTANT INFORMATION	
<input type="checkbox"/> Please do not make medication changes (RECOMMENDATIONS ONLY) <input type="checkbox"/> Please do not consider for longer-term followup (CONSULTATION ONLY)	
DATE (D/M/Y)	SIGNATURE

Contact us if you don't get a response within two weeks.

Dr. Lysak's MSP # is 67382