Dr Deb Putnam Referral Information form – to be filled in by referring physician. Please fax completed form to Saluté Family Medicine at (403)-800-3055.

Date of referral:

Patient information (label is fine)

Name:

DOB:

AHC no:

Home no: Cell no: Work no:
Preferred contact number:

Email:

Parent information (if patient is not a mature minor)

Name:

Home no: Cell no: Work no:
Preferred contact number:

Email:

Family Physician:

Office no:

Fax no:

NOTE: Patient must be aware of and be actively seeking this referral. Family physician must be actively involved, consent to continue to be the doctor of record, and consent to follow up with mental health medications prior to sending this referral.

1. What is the consultative question (including possible diagnosis) for this referral?

2. How are possible ADHD symptoms affecting the patient's mental health?

3. Has this patient had mental health diagnoses in the past? (please circle) Y N
If so, when and by whom?

What, if any, medications have been tried in the past (including dose)?

What, if any, medications are this patient currently taking?

4. Has this patient had mental health supports/treatment in the past? (please circle) Y N

If yes, who and where?

5. Are there mental health supports currently in place? (please circle) Y N
If yes, who and where?

Thank you for completing this form. Our office will contact you to confirm receipt.