



DLM121

Name at birth

First name

File No.

GUICHET D'ACCÈS EN SANTÉ MENTALE (GASM)-ADULTE
REQUEST FOR SERVICE (physicians)

Note: The masculine form is used throughout the text for ease of reading, but refers to both men and women.

Section reserved for GASM administrative use

Territory associated : Métro site Côte-des-Neiges site Parc-Extension site

IDENTIFICATION OF PATIENT - *Mandatory information*

Family name: _____ First name: _____ Sex: F M

Date of birth (yy-mm-dd): _____ Medicare Card No.: _____ Expiration (yy-mm): _____

Address: _____ Postal code: _____

Language(s) used: French English Other : _____

Tel. no. where patient can be reached: #1 () _____ #2 () _____

Contact person in case of need: _____ Relation: _____ Tel. no.: () _____

Does the user have children aged under 18 years?: No Yes Their age: _____

Does the user live with his children? : No Yes Specify (e.g.: full custody, joint custody): _____

You have been this patient's physician since (yy-mm): _____

REASON(S) FOR REQUEST FOR SERVICE (*check*)

First-line mental health evaluation and return to attending physician

First-line mental health evaluation and joint follow-up with first-line mental health team

Psychiatric evaluation¹

Other: _____

What questions do you want answered?

SYMPTOMS and/or DIAGNOSTIC IMPRESSIONS ² associated with the request for service

Describe the symptoms (with respect to mood, affect, thought and behaviour), the approximate date of their appearance, and their intensity (light, moderate, severe):

Check this box if you are attaching clinical notes to this form.

PHYSICAL and PSYCHIATRIC MEDICATION

CURRENT: (name, dosage, date first taken, side effects)

PREVIOUS: (name, dosage, date and reason for cessation or reduction)

Check this box if you are attaching clinical notes to this form.

Degree of compliance to treatment: poor moderate good excellent

IDENTIFICATION OF APPLICANT PHYSICIAN

Name of physician (in capital letters): _____
 Practice no.: _____
 Tel. no.: () _____ Fax no.: () _____
 Private practice Name of Medical clinic / GMF / CR / CRI (in capital letters): _____
 Address: _____ Postal code: _____
 Next appointment with the patient (yy-mm-dd): _____
 Date of request for service (yy-mm-dd): _____
 Signature of physician: _____

PHYSICIAN'S STAMP

¹ No psychiatric evaluation for medical or legal purposes will be conducted at the GASM or the M.E.L. (e.g., return to work, insurance, SAAQ, social aid, etc.)

² If the mental state of the user requires an urgent psychiatric evaluation (e.g., severe psychosis, suicidal crisis with high risk), please direct the user to the psychiatric emergency. On the other hand, if the situation is more in the nature of a psychosocial crisis, with or without the presence of suicidal thoughts or other psychiatric symptoms, please direct the user to the Accueil Évaluation Orientation (AEO) service of the CLSC and/or to the Crisis Centre (housing/lodging and crisis follow-up, 24/7 telephone support). (Refer to introductory page for coordinates.)

How to submit the request for service form :

GASM

Fax : 514 380-5515

Telephone : 514 731-1386, ext. 2281

Hours : 9 A.M. to 5 P.M., Monday to Friday, including holidays