HAMILTON HSO MENTAL HEALTH PROGRAM
PROFESSIONAL FEE INVOICE

PSYCHIATRIST NAME: _____ MONTH: _____ PRACTICE: _____
(Please Print) **(ONE FORM PER PRACTICE PLEASE)**

	Week 1		Week 2		Week 3		Week 4		Week 5		Total # of Patients	Total # of Min
	#	Min	#	Min	#	Min	#	Min	#	Min		
Direct Clinical Service Consultations												
Follow Ups												
Number of No Shows/Cancellations												
Case Discussion With Family Physician and/or Counsellor												
Telephone Advice												
Charting, Paperwork, Letters, Correspondence												
Administrative Meetings												
Education With Family Physician and/or Counsellor												
Education With Clinical Clerks / Residents												
Continuing Medical Education												
									TOTAL MINUTES			
									TOTAL # OF SESSIONS			

PLEASE NOTE: 1 Session = 3.5 hrs

Please return to:

Program Use Only

Total $ _____

Dept. # _____

Account # _____

Signature:_____

ONE FORM PER MONTH

White and Canary - Program Manager Pink - Program Evaluation Goldenrod - Psychiatrist's File ©H HSO MHP Revised: Apr 2005