ONTARIO MENTAL HEALTH THERAPY

Insert Patient Identification Label Here

_____

Physician Referral Form

Please fax referrals to: (416) 764-4669 (PHIPA compliant)

Patient Information:

Name _____

Phone _____ Email _____

Address _____

DOB (M/D/Y) _____ Gender _____

Preferred Method of contact: ☐ Phone ☐ Email

Referring Physician Information:

Name _____ CPSO # _____

Phone _____ Fax _____

Clinic Address _____

Please select from the following options. The patient is presenting issue(s) of:

☐ Anxiety ☐ ADHD ☐ Autism/ ASD ☐ Insomnia ☐ Depression ☐ Grief

☐ Stress ☐ Burnout ☐ Trauma ☐ Other (please specify)

Additional information:

Progress report, with patients consent after:

☐ Three Months ☐ Six Months ☐ Upon Request

Physician Signature: _____ Date: _____

261 Millway Ave Unit 14, Concord, ON L4K 4T3 Ph: (905) 996-1093 Fax: (416) 764-4669