CMAP HEALTH REFERRAL FORM FOR PSYCHOTHERAPY (SELF-REFERRAL)

*(A Psychiatric Consultation requires a referral by a Physician or Nurse Practitioner *see* **REFERRRAL FORM FOR HEALTH CARE PRACTITIONERS*)**

Centre for Mental & Psychological Health

1390 Prince of Wales Drive, Suite 110**,** Ottawa, ON K2C 3N6

CONFIDENTIAL EMAIL: cmaphealth@hushmail.com

PHONE: 1-888-691-6111; **FAX:** 1-844-210-6064

WEBSITE: cmaphealth.com

DATE: _____/_____ /_____

FIRST NAME: _____ LAST NAME: _____

DATE OF BIRTH: _____ / _____ /_____ GENDER: _____

ADDRESS: _____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

PREFERRED CONTACT #: _____ Can messages be left at this number? YES ☐ NO ☐

ALTERNATE CONTACT #: _____ Can messages be left at this number? YES ☐ NO ☐

E-MAIL: _____ Can messages be sent to this email? YES ☐ NO ☐

HOW DID YOU FIND OUR CLINIC? Family ☐ Friend ☐ Health Professional ☐ Internet Search ☐ Social Media ☐ Other ☐

Is this your first experience with Psychotherapy? YES ☐ NO ☐

Is there a therapist on our Team whom you would like to work with? YES ☐ NO ☐ Name: _____

Do you have a GP and/or NP? YES ☐ NO ☐ NAME: _____

Describe your reasons for seeking help? _____

_____

_____

Would you expect or wish others to be involved in the first appointment with you? YES ☐ NO ☐ MAYBE ☐

If YES OR MAYBE, what is their relationship with you? _____

Have you experienced any of the following?

- ☐ Addictions
- ☐ Anger Problems
- ☐ Anxiety
- ☐ Attention Problems
- ☐ Communication Problems
- ☐ Depression
- ☐ Eating problems
- ☐ Grief
- ☐ Hoarding
- ☐ Life Transition / change
- ☐ Obsessions / Compulsions
- ☐ Panic
- ☐ Phobias
- ☐ Physical Health problems
- ☐ Post-Traumatic Stress
- ☐ Relationship Issues
- ☐ Self-harm
- ☐ Suicide Attempts
- ☐ Skin picking and or Hair pulling
- ☐ Sleep problems
- ☐ Social Anxiety
- ☐ Workplace stress
- ☐ Other

Please indicate your preferred times for your Therapy appointments:

Morning 1st ☐ 2nd ☐ 3rd ☐

Afternoon 1st ☐ 2nd ☐ 3rd ☐

Evening 1st ☐ 2nd ☐ 3rd ☐

Do you have insurance that covers psychological services? YES ☐ NO ☐

If YES, NAME OF INSURANCE PROVIDER: _____

Psychotherapy is provided by a variety of regulated health care professionals including Psychotherapists, Psychologists, Social Workers, Nurses and Occupational Therapists.

Our psychological services **are not** covered by public health insurance (such as OHIP or RAMQ). If you have an employer-provided or private health insurance plan, part of or all of your therapy fees may be covered. We provide receipts for you to submit to your insurance provider.

We recommend that you contact your insurance company to confirm the details of your coverage before you make an appointment, it will help us maximize your treatment plan.

_____ _____/_____/_____

Signature **DD MM YYYY**

Thank you for reaching out; we are grateful for the opportunity to support you.

You can expect to hear from us within 48 business hours.

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