REFERRAL FORM

Upon Completion Please Fax Front and Back to 705-481-1925 or email scanned copy or PDF copy to clinic@midlandtherapy.com.
Psychiatric Referrals **MUST** be completed by a Physician

Please check all of the services that you or your client are interested in becoming involved in:

Individual Therapy Services:

- ☐ Individual Psychotherapy
- ☐ Cognitive Behavioural Therapy
- ☐ Dialectical Behaviour Therapy Skills Training
- ☐ Couples Therapy
- ☐ Addiction/Substance Use/Treatment
- ☐ Anger Management

Group Services:

- ☐ Mindfulness Group
- ☐ Dialectical Behaviour Skills Group
- ☐ Mental Health and Addictions Program

OHIP Covered Services

- ☐ Psychiatric Consultation (**Single Consult ONLY**)
- ☐ CBT Skills Group

CLIENT/PATIENT INFORMATION	REFERRAL SOURCE INFORMATION
Last Name:_____	Organization/Agency:_____
First Name:_____	Name:_____
Date of Birth:_____	Position:_____
Gender:_____	Phone:_____
Is your client/patient aware of this referral? Y / N	Fax:_____
If no, Please explain:_____	Email address:_____
_____	
Phone (Home):_____	Address:_____
Phone (Mobile):_____	
Can messages be left at the numbers provided? Y/N	Billing Number (if referred by a
Email address:_____	physician):_____
Address:_____	
Health Card Number:_____	

Alternate Contact Information

Emergency Contact Person:_____

Phone:_____

Relationship to client:_____

Guardian and Custody Status (if applicable)

Custody Status:_____

Guardian Name:_____ Phone number:_____

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1. **REASON FOR REFERRAL** (Eg.Consultation, goals for assessment, treatment, presenting problems).

2. **SUBSTANCE USE** (Current Substance, amount, frequency of use ect…)

3. **RISK ISSUES**

Risk Issue	IF YES CHECK	IF YES, WHEN	DETAILS
Suicide/attempt/ideation	☐		
Deliberate Self-Harm	☐		
Violent Behaviour	☐		
Legal Involvement	☐		
Fire Setting	☐		

4. **MEDICATIONS**

Medication	Dose/Frequency	Response & Adverse Effects

5. **AGENCIES, HOSPITALS OR THERAPIES INVOLVED WITHIN THE PAST TWO YEARS**

Completed by:_____ Signature:_____ Date:_____