

Referral Form For Individual Psychotherapy or Groups

To ensure your referral is processed promptly, please complete ALL sections.

Fax to: 647-557-3484

Client Information														
Health Card #										Version Code				
Last Name						First Name								
Street Number and Address						City, Prov				Postal Code				
Phone			Marital Status			Date of Birth		Year		Month		Day		
☐	Male	☐	Female	☐	Other	Does client speak English?				☐	Yes	☐	No	
Client Aware of Referral?		☐	Yes	☐	No	Client aware group is private Not covered by OHIP				☐	Yes	☐	No	
Background Information for Client Referral (Check All That Apply)														
☐	Specific Symptoms of Serious Mental Illness				☐	Relationship/Social Issues				☐	Medication information – any anti-depressants? Anti-anxiety? Please list			
☐	Depression diagnosis? Onset?				☐	Social Isolation				☐				
☐	Suicidal / Self Harm				☐	Substance Abuse/Addictions				☐				
☐	Type of loss (spouse, family, job?)				☐	Cognitively stable?				☐				
☐					☐					☐				
Other – Please Specify														
Client's Medical/Psychiatric Status														
☐	Stable	☐	Recent Changes – Please Specify				☐	Psychiatric Diagnosis – Please Specify						
If Client Has a Psychiatrist/Psychologist:		Last Name				First Name				Phone				
Type of Psychotherapy Requested														
☐	GROUP THERAPY					☐	Virtual			☐	In-Person			
☐	Grief Group – Adult (18+)		☐	Grief Group– Seniors (60+)		☐	Self –Esteem Group			☐	Anxiety Group (18+)			
☐	INDIVIDUAL PSYCHOTHERAPY – please specify													
Referrer Information														
Referrer:		☐	Family Physician	☐	Specialist	Billing Number								
☐	Family/Caregiver		☐	Self	☐	Power of Attorney for Personal Care / Substitute Decision Maker (SDM)					☐	Hospital		
☐	Agency – Please Specify					☐	Other – Please Specify							
Last Name						First Name								
Street Number and Address						City, Prov				Postal Code				
Phone					Ext.		Fax							
Family Physician Information (If Not The Referrer)														
Last Name						First Name						Phone		
Referrer's Signature:								Date of Referral:						