FAX COMPLETED FORM TO: 1 844 744 5314

Referring Physician/NP NAME:_______________________

Billing #____________Phone:_______________________

Address:____

FAX:____

I acknowledge that this is for a psychiatric consultation only, and that I will continue to be involved in the care of this patient.

Referring MD/NP signature: _________________________

Patient Name:

DOB: (YY/MM/DD): Current age:

HC: VC:

ADDRESS:

PHONE:

EMAIL:

REASON FOR REFERRAL

Service sought:

- Psychiatric Consultation: (OHIP, only offered in Toronto Office)
- Sleep Assessment with NP and MD (OHIP covered)
- OTN (Telemedicine consult)
    - Physician to Physician
    - Patient with Physician
- The following services are not covered by OHIP but may be covered under insurance plans:
    - Nurse Practitioner:(medication monitoring, sleep monitoring, psychotherapy)
    - Psychotherapy: (MSW, Psychotherapist, Psychologist) (for a full list, check out our services on www.wholeheartmentalhealth.com)
    - Psychoeducational testing (assessment for learning disorders/giftedness)
    - Reiki, Art Therapy

MEDICAL HISTORY: (include copy of recent blood work)

RECENT VITALS:

- Blood Pressure: _____
- HR: _______________
- Weight: ____________

ALLERGIES:

CURRENT MEDICATIONS:

Past medication trials: (name, dose, reason for stopping)

PSYCHIATRIC HISTORY:

Current therapist:

Past Diagnosis:

PLEASE CHECK ALL THAT APPLY GAD

- ○ General Worries
- ○ Chronic unexplained aches and pains

OCD

- ○ Repetitive thoughts/rituals

PANIC

- ○ Sudden panic attacks with intense anxiety

SOCIAL

- ○ Excessively shy
- ○ Refusal to do things in front of others
- ○ Refusal to go to school, work

○ **SM:**

- ○ Refusal to talk in public, but talks at home

OTHER:

- ○ Pulls out hair, eyebrows Nail biting, picking Exposure to trauma

MOOD

- ○ Sad, unhappy or depressed
- ○ No interest or pleasure in life
- ○ Changes in energy
- ○ Social withdrawal
- ○ Weight changes
- ○ Sleep disturbance
- ○ Concentration difficulties
- ○ Distinct period of elevated/irritable mood
- ○ Decreased need for sleep
- ○ Racing thoughts
- ○ Speech seems pressured
- ○ High risk activities (spending money, promiscuity)

PSYCHOSIS:

- ○ Hallucinations
- ○ Paranoia

SUBSTANCE ABUSE

- ○ Alcohol
- ○ Use of street drugs

EATING DISORDERS

- ○ Restricted intake
- ○ Purging

PERSONALITY

- ○ Recurrent suicidal ideation or attempts Intense anger
- ○ Major mood swings
- ○ Impulsive self destructive or self injurious behavior

ADHD

- ○ Attention difficulties
- ○ Hyperactivity/Impulsivity

INSTRUCTIONS

1. Please advise patient:
   - A guardian ***must be present*** at the initial assessment
   - Please bring/email report cards, psychological or psychoeducational reports
   - Patient may call 647 345 0661 or email ***intake@wholeheartmentalhealth.com*** ***(once referral is sent)***
   - No shows, or cancellations without 48 hours notice **will incur a charge *according to the OHIP billable rate*.**
   - The psychiatrist can provide CONSULTATION ONLY

2. While we cannot guarantee special requests, please indicate if this is a referral to a specific doctor: __________________

-

-