FAX COMPLETED FORM TO: 1 844 744 5314

Whole Heart
MENTAL HEALTH & WELLNESS

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 DEMOGRAPHICS:

Patient Name:_____DOB: (YY/MM/DD):_____
Current age:_____HC:_____VC:_____
Phone #_____Email:_____Other phone:_____
Address:_____Postal code:_____
CUSTODY: joint/single/other:

REASON FOR REFERRAL:

Service sought:

- Central Toronto Office Psychiatric Consultation: (OHIP)
- OTN (Telemedicine consult)
  - Physician to Physician
  - Patient with Physician
- The following services are not covered by OHIP but may be covered under insurance plans:
  - Sleep Consultation with Bridget Doan, NP
  - Psychotherapy (services listed on www.wholeheartmentalhealth.com)
  - Psychoeducational testing (assessment for learning disorders/giftedness)

MEDICAL HISTORY: (include copy of recent blood work)

ALLERGIES:
CURRENT MEDICATIONS:

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

RECENT VITALS:

- Blood Pressure: _____
- HR: _____
- Weight: _____

PSYCHIATRIC HISTORY:

Current therapist:

Past Diagnosis:

PLEASE CHECK ALL THAT APPLY

GAD
- General Worries
- Chronic unexplained aches and pains

OCD
- Repetitive thoughts Repetitive 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 a 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 to book appointment
   - ***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: _____