WHOLE HEART
MENTAL HEALTH & WELLNESS

FAX COMPLETED FORM TO: 1 844 744 5314

Referring Physician/NP:___________________________

Billing #_____________

Phone:______________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):
HCN:
ADDRESS:

PHONE:
EMAIL:***Please ensure email address is provided*

REASON FOR REFERRAL:

SERVICE REQUESTED

- **Psychiatric Consultation:** (OHIP)- MD/NP referral required
- **Sleep Assessment** with NP & MD (OHIP covered):
  - Please identify the specific sleep issue:
  - Please forward all labs and/or sleep study/assessments
  - Therapy is not covered under OHIP, a referral is not required for therapy
- The following services are **not** covered by OHIP (but may be covered under insurance plans)
  - Nurse Practitioner:(medication monitoring, psychotherapy) Patient may email Bridget@wholeheartmentalhealth.com
  - Psychotherapy: (MSW, Psychotherapist, Psychologist) (for a full list, check out our services on www.wholeheartmentalhealth.com) Patient may email daisy@wholeheartmentalhealth.com
  - Psychoeducational testing: patient may email gkirsh@rogers.com

MEDICAL HISTORY: (include copy of recent blood work if applicable)

RECENT VITALS:

- Blood Pressure: ______HR: ___Weight: ___

ALLERGIES:

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

PAST PSYCHIATRIC HISTORY: Current/Past treatment

IMPORTANT: Fax **ALL notes of past** assessments

1. Please advise patient: A guardian must be present at the initial assessment
2. No shows, or cancellations within 48 hours notice are subject to a charge
3. Psychiatric consultation is only available at this time
4. All appointments will be conducted virtually due to the pandemic
5. We cannot provide treatment for primary eating disorders, Psychosis, Bipolar Disorder or substance abuse.
6. FOR ADHD ASSESSMENT:
   1. Please ask **patient/caregiver to obtain ratings from the teacher** and caregiver **they can access** https://www.adhdratingscales.com, select Dr. Wiesenthal as the provider
   2. Patient/family send in report cards to intake@wholeheartmentalhealth.com prior to the assessment

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

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)
- Suicidal

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
- Self harming behavior

ADHD

- Attention difficulties
- Hyperactivity/Impulsivity
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