Fax referral form to 289 372 0463

WHOLE HEART
MENTAL HEALTH & WELLNESS

PATIENT INFORMATION	
Last name, First Name: _____ DOB (YYYY/MM/DD): _____ Phone number:_____ Address:_____ Health Card No._____VC:_____ **Email** (REQUIRED): **PLEASE WRITE CLEARLY- advise patient to email us to book an appointment** _____ ○ **Is this a WHW client Y/N**	**Referring Physician/NP INFORMATION** Name:_____ Billing Number:_____ Phone:_____ Fax:_____ Address:_____ *I acknowledge that this referral is for consultation only* _____ 1. For faster service, ask patient to email intake@wholeheartmentalhealth.com 2. For therapy (not covered by OHIP), ask patient to email: daisy@wholeheartmentalhealth.com 3. **EXCLUSION CRITERIA:** - Psychosis - Bipolar Disorder - Primary Substance Use disorder - Eating disorders - Adults over 22 years old
REASON FOR REFERRAL: ○ Diagnostic Assessment: ○ Medication Review **List all current symptoms:** **CHECK ALL THAT APPLY:** ○ GAD General Worries/Aches/Pains ○ OCD: Repetitive Thoughts/Rituals ○ PANIC: Sudden Panic Attacks ○ SOCIAL: Excessively Shy/School Avoidance ○ MOOD: sad, unhappy, or depressed ○ ADHD: Attention difficulties/ HyperactivityImpulsivity	**CURRENT AND PAST MEDICATION TRIALS:** ○ N/A ○ List all trials, doses, outcomes **Psychiatric History:** Send in **all past reports** **Medical History:**