



WHOLE HEART
MENTAL HEALTH & WELLNESS

FAX COMPLETED REFERRAL FORM TO: 289-372-0463

For faster service, ask patient to email intake@wholeheartmentalhealth.com for appointment

PATIENT INFORMATION

NAME: _____ , _____
(LAST) (FIRST)

PHONE #: _____

DOB (YY/M/D): _____ / _____ / _____

HEALTH CARD # _____ VC: _____

ADDRESS: _____

EMAIL (REQUIRED): _____

REASON FOR REFERRAL

PSYCHIATRY CONSULTATION (OHIP): for up to 22 years of age

- DIAGNOSTIC ASSESSMENT/CLARIFICATION
- MEDICATION REVIEW
- ADHD MEDICATION CONSULTATION (send psychoeducational assessment)
- SECOND OPINION (INCLUDE PAST REPORTS)
- NEW!** CBT with Family doctors (anxiety)
- Family doctor Medication Clinic (prescribe and monitor medications): **As this may impact your FHO/FHN, Please indicate YES/ NO**

BRIEFLY DESCRIBE CURRENT SYMPTOMS:

CHECK ALL THAT APPLY:

- General worries
- OCD: Repetitive thoughts or rituals
- Panic attacks
- Social: Shy, school avoidance
- Mood: sad/unhappy
- ADHD: attention/hyperactivity/impulsivity
- OTHER:**

NURSE PRACTITIONER SERVICES

- Adult ADHD Assessment (23 years +) \$ 700
- Adult Psychiatry Assessment(23 years +) \$ 700
- Medication Monitoring (22 years and under) \$ 100/30 minutes

CURRENT MEDICATIONS:

Has this patient seen or is seeing a psychiatrist YES / NO (include reports)

PAST MED TRIALS:

IS THIS A WHW CLIENT? YES / NO

MEDICAL HISTORY:

REFERRING MD/NP INFORMATION

NAME: _____

BILLING #: _____

PHONE: _____

I acknowledge:

- This is consultation only and I will resume care of the patient.
- WHW does not assess psychosis, bipolar disorder, substance disorders, or eating disorders.
- Patient is 22 years old or younger (for Psychiatry only)

FAX: _____

ADDRESS: _____

THERAPY may be covered under insurance. Patients can email therapy@wholeheartmentalhealth.com

- Individual, couple, family, parent counselling
- Educational Therapy or Tutoring
- Psychoeducational Assessment
- Registered Nutrition Consultation

Groups:

- DBT Skills
- Study Skills
- Sanchin Martial Arts (6-12)