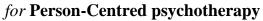
THE MEDICAL CLINIC





REFERRING FORM FOR NEW PATIENT

Most sessions are virtual and or phone sessions and some in person depending on physicians availability when

taking on new clients.

*****IMPORTANT: Fa							
Message: Due to the high							
to patients. Therefore, <u>if y</u> the patient at our clinic.		s not receive a phone cal	l from ou	r office in 2 weeks,	we will no	<u>t be able to sc</u>	<u>hedule</u>
We will fax your office if	f your referral has						
It is still the responsibility	y of the family do	ctor to seek other resource	es of thera	py for the patient.			
A) Date of Referral]	Referring Physician Nar	ne:		Physic	ian Billing No	I <u>. </u>
Physician's Tel. No		No (If yes, it	Ph	ysician's Fax No <u>.</u>			
Are you in a Roster I	Practice? Yes	No (If yes, it	is very in	portant for you to	specify thi	is)	
		does psychotherapy in ou our patient?		will this affect your i	remuneratio	on ?	
	Cormation First name:LAST name:						
Gender	DOB: Day_	Month		Year	Marital Status:		
Ohip Card No. Version Code E-Mail							
Address:							
Home Phone No Prefer Contact Phone No							
Education level:	High School not	completed 🛛 🗆 High So	chool	□ College	D Post-	graduated	
1. Types of therapy requ	uested:						
□ Supportive Thera	py 🛛 Interp	ersonal Therapy	Group The	erapy 🛛 Medicati	ion		
Cognitive Behavi	oral Therapy CB	r : Is the patient capable a	and motiv	ated to do reading ar	nd writing a	assignments?	□ Yes □ No
2. Main symptoms:				_		-	
3. Psychiatric Diagnoses:Current medications prescribed:							
4. Please confirm if: a)	The patient's me	ntal or emotional problem	is are caus	ed by a physical co	ndition? L	⊐ Yes □	No
b) The patient has been medically cleared by me for psychotherapy treatment? \Box Yes \Box No							
c)	The patient has h	ad Suicidal attempt(s)?	□ No,	if Yes: Current	🗆 Past (s	specify when)	
d)	The patient has h	ad Violent behaviors?	□ No,	if Yes: Current	🗆 Past (s	specify when)	
e)	The patient suffer	rs from Schizophrenia?	□ No,	if Yes: Current	🗆 Past (s	specify when)	
5. Has this patient recentl* Psychiatrist's Name:		care of a psychiatrist?	□ No	□ Yes, if yes plea Phone numb	•	name and conta	act # of the psychiatrist
Will the psychiatrist co	ontinue to follow	the patient as needed and	manage n	nedication?	Yes 🗆	No 🗆	
6. Does this patient requir (If yes, what is it?)		essment, Insurance, Leg			Yes 🗆	No 🗆	
7. Additional Info:							

***Does the patient want to be in <u>GROUP</u> therapy? Yes I No I if yes we may arrange an appointment for group assessment

***Does the patient willing to see a **non-physician** therapist? We may arrange an **earlier** appointment, fees will apply (sliding scale).

***Is your client interested in virtual or phone sessions? Yes \Box No \Box