THE MEDICAL CLINIC
for **Person-Centred psychotherapy**

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**: Family doctor please confirm you have informed the patient of the following message. ☐**Yes**
Message: Due to the high volume of patient demand, this clinic has limited openings and limited types of therapies we can offer to patients. Therefore, **if your patient does not receive a phone call from our office in 2 weeks, we will not be able to schedule the patient at our clinic.**
We will fax your office if your referral has been declined.
It is still the responsibility of the family doctor to seek other resources of therapy for the patient.

A) Date of Referral________________ **Referring Physician Name:** ______________________**Physician Billing No.**________________

Physician's Tel. No. ____________________________________ **Physician's Fax No.**______________________________
Are you in a Roster Practice? Yes______ **No**_____ **(If yes, it is very important for you to specify this)**
If your patient sees a family doctor who does psychotherapy in our clinic, will this affect your remuneration? _____
If yes, will you consider **de-rostering** your patient? _______________

B) Patient Information 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 School ☐ College ☐ Post-graduated

1. Types of therapy requested: ____

☐ Supportive Therapy ☐ Interpersonal Therapy ☐ Group Therapy ☐ Medication

☐ Cognitive Behavioral Therapy **CBT**: Is the patient capable and motivated to do reading and writing assignments? ☐ Yes ☐ No

2. Main symptoms: ____

3. Psychiatric Diagnoses: ____________________________________**Current medications prescribed:** __________________________

4. Please confirm if: **a)** The patient's mental or emotional problems are caused by a **physical** condition? ☐ *Yes* ☐ *No*

b) The patient has been **medically cleared** by me for psychotherapy treatment? ☐ *Yes* ☐ *No*

c) The patient has had **Suicidal** attempt(s)? ☐ No, if Yes: ☐ Current ☐ Past (specify when) __________________

d) The patient has had **Violent** behaviors? ☐ No, if Yes: ☐ Current ☐ Past (specify when) __________________

e) The patient suffers from **Schizophrenia**? ☐ No, if Yes: ☐ Current ☐ Past (specify when) __________________

5. Has this patient recently been under the care of a **psychiatrist?** ☐ No ☐ Yes, if yes please provide name and contact # of the psychiatrist
* Psychiatrist's Name**:** ____ Phone number: ________________________________
Will the psychiatrist **continue** to follow the patient as needed and manage medication**?** Yes ☐ No ☐

6. Does this patient require any specific assessment**, Insurance, Legal, CAS,** etc. involvement**?** Yes ☐ No ☐
(If yes, what is it?) ____

7. Additional Info: ____
***Does the patient want to be in **GROUP** therapy? Yes ☐ No ☐ 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).
☐Yes ☐ No
***Is your client interested in virtual or phone sessions? Yes ☐ No ☐