



Referring Physician	Date:
Name of Referring Physician:	Specialty & Billing #:
Main Telephone #:	Backline/Unlisted Telephone #:
Fax #:	Email:
Address:	Family Physician's Name & Phone Number:
Referring Physician's Signature:	Referral: <input type="radio"/> Urgent <input type="radio"/> Non-Urgent
Patient Demographics	
Name:	D.O.B. (DD/MM/YYYY):
HIN (& Version Code):	<input type="radio"/> Male <input type="radio"/> Female
Address & Phone #:	
Should the patient be contacted directly with an appointment? <input type="radio"/> Yes <input type="radio"/> No	
If "No", Provide name & telephone number of a contact person:	
Able to speak English? <input type="radio"/> Yes <input type="radio"/> No	If "No", language(s) spoken:
Known Health Conditions & Diagnoses:	
Clinical Problem:	
Expectations of Referring Physician - Clarification of diagnosis, ongoing treatment, etc...	

IMPORTANT: To facilitate timely processing of the referral & scheduling an assessment for the patient, please:

- **Ensure** the referral is complete & that the patient's family physician is informed of the referral to our clinic
- **Include** the patient's medical, psychiatric and medication history
- **Include** relevant consultations and discharge summaries, laboratory results, and radiology/imaging reports; especially any past psychiatric assessments and discharge summaries.
- **Please note:** If we require further information, we will contact the referring physician to follow-up on the referral before confirming our involvement or making an appointment for the patient.

Please Fax Completed Form to 416-586-3231

For more information, please contact Anne Marie Vico at 416-586-4800 ext 5192