Centre for Mental & Psychological Health
1390 Prince of Wales Drive, Suite 110, Ottawa, ON K2C 3N6
CONFIDENTIAL EMAIL: cmaphealth@hushmail.com
PHONE: 1-888-691-6111; FAX: 1-844-210-6064
WEBSITE: cmaphealth.com

Private psychotherapy referral form

You can fill out the form online by visiting https://cmaphealth.com/private-psychotherapy-referral-form/

Psychotherapy by our therapists is not covered by Provincial Healthcare. However, it is covered by most major insurance providers.

Fill out this form

Date

SECTION A: REFERRER DETAILS

Name *

College Registration #

TYPE

☐ Family Physician ☐ Nurse Practitioner ☐ Psychiatrist ☐ Other healthcare provider ☐ Other Physician

Clinic/Contact Address

Address Line 1

Address Line 2

City

State / Province / Region

Postal Code

Country

Phone *

FAX

Email *

HOW DID YOU FIND OUR CLINIC?

☐ Family ☐ Friend ☐ Health Professional ☐ Internet Search ☐ Social Media ☐ Other

SECTION B: PATIENT INFORMATION

Name *

DOB

Gender

Coverage for Psychotherapy

☐ INSURANCE ☐ PATIENT

Provincial Health Card Number #

PREFERRED CONTACT # *

ALTERNATE CONTACT #

Email Address *

Address

Address Line 1

Address Line 2

City

State / Province / Region

Postal Code

Country

EMPLOYMENT STATUS

☐ EMPLOYED ☐ UNEMPLOYED ☐ ON LONG-TERM LEAVE

What languages can the patient communicate in?

Legal Involvement?

☐ Yes ☐ No

If yes, please describe

SECTION C: CLINICAL DETAILS

Reasons for the referral

Is patient currently engaged in psychotherapy treatment?

☐ Yes ☐ No

Does the Patient have any of the following?

- ☐ Addictions
- ☐ Attention Problems
- ☐ Eating problems
- ☐ Life Transition / change
- ☐ Phobias
- ☐ Relationship Issues
- ☐ Skin picking and or Hair pulling
- ☐ Workplace stress
- ☐ Anger Problems
- ☐ Communication Problems
- ☐ Grief
- ☐ Obsessions / Compulsions
- ☐ Physical Health problems
- ☐ Self-harm
- ☐ Sleep problems
- ☐ Other
- ☐ Anxiety
- ☐ Depression
- ☐ Hoarding
- ☐ Panic
- ☐ Post-Traumatic Stress
- ☐ Suicide Attempts
- ☐ Social Anxiety

Please provide any relevant information regarding the patient's situation regarding the previously ticked problem areas.

Please include all previous patient investigations for mental health treatment such as psychological tests and lab tests relevant for assessment.

Does the patient have any current medical problems?

☐ Yes ☐ No

If yes, please provide details

Current Medications:

Signature

Date / Time

PLEASE INCLUDE ALL PREVIOUS PSYCHIATRY / PSYCHOLOGICAL ASSESSMENTS

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