Centre for Mental & Psychological Health
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Ontario Psychiatry Consultation Referral Form

You can fill out the form online by visiting https://cmaphealth.com/ontario-psychiatry-consultation-referral-form/

Date *

REFERRAL SOURCE

Referrer Name *

Billing No #

CPSO No #

TYPE *

☐ Family Physician ☐ Nurse Practitioner ☐ Psychiatrist ☐ Other Physician

ARE YOU THE PATIENT'S GP? *

☐ Yes ☐ No

If NO, please provide patient's GP details so the report can be sent to them. GP Name:

PLEASE NOTE: IF YOU ARE NOT THE PATIENT'S GP AND DO NOT CONSENT TO FOLLOW-UP CARE, THE REFERRAL WILL BE DECLINED

Clinic 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

CONSENT

I understand that this referral is for single consults and I agree to manage the follow-up care for the patient? *

☐ Yes

Is the patient aware of and in agreement with this request for service? *

☐ Yes

Does the patient consent to the sharing of this referral with other health care providers? *

☐ Yes

PATIENT INFORMATION

Patient Name *

First

Last

Date of Birth

Gender

Allergies

Provincial Health Card Number #: *

PREFERRED CONTACT # *

Can messages be left at this number?

☐ Yes ☐ No

ALTERNATE CONTACT #

Can messages be left at this number?

☐ Yes ☐ No

Email *

Can messages be sent to this email?

☐ Yes ☐ No

Home Address *

Address Line 1

Address Line 2

City

State / Province / Region

Postal Code

Country

What languages can the patient communicate in?

DOES THE PATIENT HAVE COVERAGE FOR PSYCHOTHERAPY?

☐ Yes ☐ No

IS THE PATIENT CURRENTLY RECEIVING PSYCHOTHERAPY

☐ Yes ☐ No

PAYMENT

☐ Patient ☐ Insurance

EMPLOYMENT STATUS

☐ EMPLOYED ☐ UNEMPLOYED

Legal Involvement?

☐ Yes ☐ No

If yes, please describe

REASON FOR THE REFERRAL

☐ Psychiatric Diagnosis

☐ Treatment Review and Recommendations

☐ Second Opinion

Patient Presenting History:

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
☐ Worry
☐ Anxiety
☐ Depression
☐ Hoarding
☐ Panic
☐ Post-Traumatic Stress
☐ Suicide Attempts
☐ Social Anxiety
☐ Other

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

Does the patient have any current medical problems? If yes, please provide details.

Has the patient had any previous psychiatry assessments? If YES, please include these with the referral. *

Has the patient had previous psychological assessments? *

Has the patient had any previous mental health treatment? If YES, please provide details.

Current and Known Past Medications:

Signature *

Date *

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