cmaphealth

PHYSICIAN REFERRAL FORM

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Patient Information

First Name *	Last Name *		
Address			
Address 2			
City	Prov.	Postal Code	
Phone Number *	E-Mail Address *		
Date of Birth (DD/MM/YY) *	Health Card *	Coverage for Psychotherapy?	
Gender MALE FEMALE OTHER			

Physician Information

Physician's First Name *	Physician's Last Name *		
Physician's Address			
Physician's Address 2			
Physician's City	Phys. Prov.	Phys. Postal Code	
Billing Number *	Physician's Phone Number*	Fax Number *	
Specialty *	Physician's E-Mail Address		
Family Physician Psychiatrist Nurse Practitioner Other Physician			

Are you the patient's GP? If No please provide the GP's Details so the report can be sent to them. Yes No

Reason for Referral: You would like your patient to be considered for (Check all that apply):

☐ Ketamine Assisted Psychotherapy ☐ Esketamine (Intranasal)

Patient's Primary Diagnosis? *

☐ Depression ☐ Anxiety Disorder ☐ Post Traumatic Stress Disorder ☐ Obsessive Compulsive Disorder ☐ Alcohol Use
☐ Pain

Does the patient have any of the following?

☐ Addictions ☐ Phobias ☐ Skin picking and or Hair pulling ☐ Workplace stress ☐ Anger Problems
☐ Attention Problems ☐ Relationship Issues ☐ Sleep problems ☐ Communication Problems ☐ Grief
☐ Eating problems ☐ Life Transition / change ☐ Worry ☐ Self-harm ☐ Obsessions / Compulsions
☐ Anxiety ☐ Depression ☐ Hoarding ☐ Panic ☐ PTSD
☐ Suicide Attempts ☐ Social Anxiety ☐ Psychosis ☐ Bipolar Disorder ☐ Coping with terminal illness
☐ Other

Please list any other current medical illnesses and medications.

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Psychiatric Medication History.

Does the Patient have any of the following conditions?

- ☐ Poorly controlled hypertension
- ☐ CAD/CVA/Intracranial bleed
- ☐ AVM/Aneuryms
- ☐ VP shunt
- ☐ Pregnancy

Consent:

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 sharing this referral with other health care providers?

☐ Yes

Has the patient had the following treatments before?

☐ ECT ☐ TMS

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

☐ Yes ☐ No

Is the patient under the care of a psychiatrist? If yes please provide the details of the treating psychiatrist.

☐ Yes ☐ No

Has the patient had previous psychological assessments? If yes please provide the report if available.

☐ Yes ☐ No

What languages can the patient communicate in?

How did you hear about CMAP Health?

PLEASE SEND ALL PERTINENT CLINICAL SUMMARIES/LAB TESTS/PHYSICAL EXAM FINDINGS

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

Additional Documents Attached ☐

Signature of Referring Physician

Date of Referral