Upon Completion Please Fax Front and Back to 705-481-1925
or Email a Scanned Copy to clinic@midlandtherapy.com
Psychiatric Referrals Must Be Completed by a Physician

REFERRAL FORM

Please check **all** of the services that you or your client are interested in becoming involved in:

- ☐ Cognitive Behavioral Therapy
- ☐ Dialectical Behavior Therapy Skills Training
- ☐ Substance Use Treatment / Referral
- ☐ PTSD Treatment
- ☐ Anger Management
- ☐ Individual Psychotherapy
- ☐ Relaxation Therapy

Group Therapy Sessions:

- ☐ CBT (This Group Requires a Physician's Referral)
- ☐ DBT Skills Training
- ☐ Young Adults Group (18-24)
- ☐ Seniors Group
- ☐ Family Support Group

☐ Psychiatric Consultation/Assessment (Requires Physician's Referral)

CLIENT/PATIENT INFORMATION	REFERRAL SOURCE INFORMATION
Last Name: _____ First Name: _____ Date of Birth: _____ Gender: _____ Is your client/patient aware of this referral? Y/N If no, please explain: _____ _____ Phone (Home): _____ Phone (Mobile): _____ Can messages be left at the numbers provided? Y/N Email address: _____ Address: _____ Health Card Number: _____	Organization/Agency: _____ _____ Name: _____ Position: _____ (*Referrals for Psychiatric Services must be made by a Physician) Phone: _____ Fax: _____ Email Address: _____ _____ Address: _____ _____ _____ Billing number (if referred by a physician): _____

ALTERNATE CONTACT INFORMATION

Emergency Contact Person: _____
Phone: _____
Relationship to Client: _____

Guardian and Custody Status (if applicable)

Custody status: _____

1. Guardian Name: _____
   Phone: _____
2. Guardian Name: _____
   Phone: _____

North Simcoe Therapy Network

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1. **REASON FOR REFERRAL** (e.g., consultation, goals for assessment, treatment, presenting problems)

2. **SUBSTANCE USE** (current substances, amount, frequency of use, etc.)

3. **RISK ISSUES**

RISK ISSUE	CHECK IF YES	IF YES, WHEN	DETAILS
Suicide attempt / ideation	☐		
Deliberate self-harm	☐		
Violent behavior	☐		
Legal involvement	☐		
Fire Setting	☐		

4. **MEDICATIONS**

MEDICATION	DOSE / FREQUENCY	RESPONSE & ADVERSE EFFECTS

5. **AGENCIES, HOSPITALS OR THERAPIES INVOLVED WITHIN THE PAST TWO YEARS**

Completed by:

_____ _____ _____

Print Name and Credentials | Signature | Date: (DD/MM/YY)