



Referral Form

For Physician, Nurse Practitioner & Community Referrals
Fax completed referrals to 1-855-710-7865 or
email a scanned copy/PDF to clinic@midlandtherapy.com

. Only OHIP services MUST be completed by a Physician or Nurse Practitioner.

PSYCHOTHERAPY SERVICES

- ☐ Individual Psychotherapy
- ☐ Cognitive Behavioral Therapy
- ☐ DBT Skills Training (Adults/Children)
- ☐ Addictions Counselling and Referrals
- ☐ Indigenous Services (no cost/NIHB)
- ☐ Child and Youth Services (Individual and Group)
- ☐ Couples Counselling

LOW COST SERVICES

- ☐ Low Cost Counselling
- ☐ Low Cost Groups

PSYCHIATRIC SERVICES/ OHIP COVERED SERVICES

- ☐ CBT Group therapy
- ☐ Psychiatric Consultation
(Single Consult ONLY)

PATIENT INFORMATION

First Name: _____ Last Name: _____

Birth Date: _____ Gender: ☐ Male ☐ Female

Address: _____ PHN: _____

City: _____ Province: _____ Postal Code: _____

Email: _____ Cell Phone: _____

Emergency Contact _____ Phone: _____

REFERRAL AGENCY INFORMATION

Agency/Office name/Organization: _____

Name: _____ Position _____

Phone: _____ Fax: _____

Address: _____

Billing Number: _____

REASON FOR REFERRAL

Referral note: Please provide relevant clinical information on Page 2.

Completed by: _____

Signature _____

Date _____

PRESENTING PROBLEMS / GOALS / TREATMENTS

SUBSTANCE USE • CURRENT SUBSTANCE, AMOUNT, FREQUENCY OF USE, ETC

RISK ISSUE

MEDIACTION

Name: _____ Dose/Frequency: _____

Response & Adverse Effects: _____

Name: _____ Dose/Frequency: _____

Response & Adverse Effects: _____

Name: _____ Dose/Frequency: _____

Response & Adverse Effects: _____

AGENCIES, HOSPITALS OR THERAPIES INVOLVED WITHIN THE PAST TWO YEARS

Completed by: _____ Signature: _____ Date: _____