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COUNSELLING SERVICES

Out-Patient Consultation Referral Form

Important Information:

- Upon referral approval, patients will meet a psychiatrist for a single consultation.
- If the referring physician consents to take on caring for patients once the psychiatric consultation is finished, the referral will be authorized.
- The referring office is supposed to inform the patient directly if the recommendation is denied.

Consulting Psychiatrist: Dr. Angela Han
Referral Date:

PATIENT INFORMATION (All fields are required)

- **First Name:**
- **Last Name:**
- **Address:**
- **Unit number (if applicable):**
- **City/Town:**
- **Postal Code:**
- **Date of Birth (yyyy/mm/dd):**
- **Phone Number:**
- **OHIP Number:**
- **Version Code:**
- **Email:**
- **Sex:** ☐ Male ☐ Female ☐ Other

REFERRING PHYSICIAN INFORMATION (All fields are required)

- **Physician's Name:**
- **Referring Physician's OHIP Billing Number:**
- **Clinic Address:**
- **Phone Number:**
- **Fax Number:**

Find Your Strength Counselling Services
1885 Glenanna, Pickering, ON, L1V 6R6
Tel: 289-923-2991 Fax: 416-764-8559
Email: info@findyourstrength.ca

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REASON FOR REFERRAL

(Please include your targeted symptoms and goals of treatment)

MEDICAL HISTORY

CURRENT MEDICATIONS

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ADDITIONAL INFORMATION

	Yes	No
Does the patient currently have a psychiatrist?	☐	☐
Voicemail Permission:	☐	☐
Does the referring physician agree to follow up on recommendations and provide ongoing care?	☐	☐

Incomplete forms may result in delays or refusal of referral.

We will attempt to contact the patient twice for appointment scheduling. If we are unable to reach the patient, we will notify the referring provider.

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