



# HEALTHY MINDS *Clinic*

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## REFERRAL FORM

### Please Note:

- WE DO NOT OFFER EMERGENCY OR CRISIS SERVICE
- Please print clearly and ensure your contact information is correct. Complete all forms
- We will contact the family to set up the assessment appointment.
- Include any relevant medical reports, psychological reports, and copies of previous psychiatric consultations or discharge summaries, along with Consent to Release Health Information Form. Failure to do so could result in a delay of the referral process.

Date of Referral:

Patient Name:

Gender: Male Female

Date of Birth:

PHN#:

### REFERRAL SOURCE INFORMATION:

Physician Name:

Billing # (if applicable):

Address:

Phone:

Fax:

### GUARDIAN INFORMATION:

Name:

Relationship to Client:

Address:

Home Telephone:

Work Telephone:

Cell:

Email Address:

**SCHOOL INFORMATION:**

**Name:**

**Address:**

**Phone Number:**

**Fax Number:**

**School Grade Level:**

**Teacher's Name:**

**ACADEMIC HISTORY:**

<b>Academic History</b>	<b>Yes</b>	<b>No</b>	<b>Unsure</b>	<b>If Yes,</b>
<b>Currently performing functioning below grade level</b>				<b>Years below grade level</b>
<b>Has psychological testing for academic learning problems be given</b>				<b>List and attach testing completed</b>

**CURRENT CONCERNS:**

<b>Concern</b>	<b>Check off current specific signs and symptoms that apply</b>	<b>How long has the client had these symptoms (months-years)</b>
<b>Anxiety</b>	<input type="checkbox"/> <b>Phobias</b> <input type="checkbox"/> <b>Nightmares</b> <input type="checkbox"/> <b>Obsessive Compulsive</b> <input type="checkbox"/> <b>Somatic Complaints</b>	
<b>Depression</b>		

<b>Bipolar Mood Disorder</b>		
<b>Psychotic Disorder</b>		
<b>Attention-Concentration</b>		
<b>Autism, Asperger's, Pervasive Developmental Delay</b>		
<b>Behaviour</b>		
<b>Social</b>		

<b>Substance(s) Used</b>		
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<b>Is there a history of any of the following</b>	<b>Yes</b>	<b>No</b>	<b>Unsure</b>
<b>Developmental handicap</b>			
<b>Head Injury with Loss of Consciousness</b>			
<b>Violent Behaviour</b>			
<b>Suicidal Attempts</b>			
<b>Self Harming Behaviour</b>			
<b>Legal Involvement</b>			
<b>Hospitalizations</b>			

**Past-Present Medications (Psychotropic and non-psychotropic):**

<b>Medication</b>	<b>Dose Frequency</b>	<b>Comments</b>	
		<b>Past</b>	<b>Present</b>

**LIST OF OTHER SERVICE PROVIDERS PRESENTLY INVOLVEMENT (MCFD, COMMUNITY AGENCIES, ETC.)**

<b>NAME</b>	<b>DURATION</b>	<b>OUTCOME COMMENTS</b>