Stress ▶ **T**rauma ▶ **A**nxiety ▶ **R**ehabilitation ▶ **T**reatment

32 Park Road
Toronto, Ontario
M4W 2N4
Tel: (416) 598-9344 Fax: (416) 598-8198

S.T.A.R.T. Clinic Referral Form

<u>If you would like to refer a patient to the clinic please complete the following two pages and return this form to us by mail or fax:</u>

PLEASE NOTE: The subject you are referring to us is referred for a consultation. We will examine a variety of treatment options as per the needs of the patient and the availability of treatment.

Date of Referral:_____

REFERRING PHYSICIAN:_____

Address:_____

Telephone#:_____

Fax#:_____

Billing#:_____

PATIENT NAME:_____

(LAST NAME) **(FIRST NAME)**

Address :_____

Tel Home#:_____

Cell #:_____

Can a confidential message be left on patients voicemail Yes___ No___

Date of Birth Day_____ Month_____ Year_____ Age____

Marital Status _____ OHIP#_____

PURPOSE OF REFERRAL (MUST BE SPECIFIED)

( ) Psychiatric Diagnostic Consultation

( ) GP Psychotherapy Consultation

( ) Psychologist (not covered by OHIP) please call for fee.

( ) Attentional/Learning Difficulties

( ) Cognitive Behavioural Therapy 16 week program

( ) Naturopathic Doctor (not covered by OHIP) please call for fee.

( ) Mindfulness Based Cognitive Therapy 12 week program (not covered by OHIP) please call for fee.

Does the patient have a drug plan?
( ) Yes ( ) No

Would the patient be willing to pay a fee for service?
( ) Yes ( ) No

Is this patient currently in treatment with a mental health professional?
( ) Yes ( ) No ( ) Unsure

If yes, please name the mental health professional: _____

Which of the following would your patient need assessment for :(*check all that apply*):

( ) Panic Disorder with Agoraphobia
( ) Panic Disorder without Agoraphobia
( ) Obsessive Compulsive Disorder
( ) Social Phobia
( ) Generalized Anxiety Disorder
( ) Bipolar Disorder
( ) Post traumatic Stress Disorder
( ) Specific Phobia
( ) Attentional Difficulties
( ) Learning Difficulties
( ) Major Depressive Disorder
( ) Pain Disorder

Please check all items that apply to this patient:
( ) current substance abuse history ( ) history of violence
( ) current alcohol abuse history ( ) suicide attempt (when?) _____
( ) hallucinations/delusions (past/present) ( ) currently has suicidal ideation
Description of Current Problem: _____
_____
_____
_____

Current Medications: _____
_____
_____
_____

Other Relevant Past Assessments and Consultations (e.g. Medical Illnesses, Pertinent Lab Tests/ Physical Exam Findings, Past Psychiatric History, etc.):

_____
_____
_____

Has this patient been an inpatient ( ) Yes ( ) No ( ) Unsure
If yes, where and when? _____