OUTPUT MENTAL HEALTH REFERRAL

Telephone: (905) 472-7011

Fax: (905) 472-7371

Inform your patients that they will be contacted by OPMH staff once a fully completed referral form has been received.

Treatment modality and length of treatment is at the discretion of OPMH staff and psychiatrists.

PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

Hospital MRN #: ______________________________

Patient Name : ______________________________
Last First

Date of Birth: ____________________ Sex: F M
DD/MM/YYYY

Health Card #: ________________ Version Code: _______

Address: ________________________ Postal Code: ______

Daytime Tel #: ______________________________

Alternate Tel #: ______________________________

Email: ______________________________

Date Referral:	**Physician Name:**	
Billing #:	**Physician Tel. #:**	**Physician Fax #:**

Reason for Referral

- ☐ Group therapy only
- ☐ Psychiatric / Medication Consultation only

Specify: ______________________________

History of Psychiatric Intervention / Problem(s)

Please attach all previous psychiatric or psychological reports

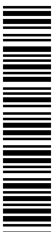
- ☐ Anxiety
- ☐ Depression
- ☐ Other: ______________________________

Significant Medical Illness

Diagnoses (if known)

Medication and Dosage

Signature	Date



Please note that OPMH services excludes the following:

1. We do not provide opinions for third party such as CAS, court, insurance, workplace issues, custody, disability.
2. We do not do ADHD and forensic assessments / treatments, or MVA assessments.
3. We are not an urgent care service. If your patient is having an emergency, please direct them to their nearest hospital or call (905) 310-COPE.

OPMHR (5/15)