REFERRAL FORM

Thrive Together
MENTAL WELLNESS CENTRES
Phone: 343-882-6766
Fax: 343-882-6768
WeThriveTogether.ca

After completing, please fax to **343-882-6768**

Date of referral:

_____/_____/_____
YYYY MM DD

PATIENT CONTACT INFORMATION

_____
FIRST NAME

_____
LAST NAME

DOB _____/_____/_____
YYYY MM DD

_____
CELL PHONE

_____
ALTERNATE PHONE

_____
PHONE

_____
ADDRESS

_____ _____
CITY POSTAL CODE

_____
EMAIL

_____
HEALTH CARD NO.

_____
VERSION CODE

PATIENT HISTORY

Are there current court/medical legal and/or custody matters? (Please provide details if applicable) ☐ YES ☐ NO

Previous Diagnosis ☐ YES ☐ NO

If YES, identify diagnosis: _____

_____

_____

MEDICATION AND DOSAGE (CURRENT)

MEDICATION	DOSAGE	DATE

Psychiatric/Medical History: _____

_____

_____

_____

_____

_____

_____

(please attach all relevant documents, assessment reports, and labs)

Current Vitals

Resting Blood Pressure: _____

Resting Heart Rate: _____

Height (cm): _____

Weight (kg): _____

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KINGSTON / OTTAWA
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REASON FOR REFERRAL (PLEASE INDICATE ALL THAT APPLY)

- ☐ Insomnia
- ☐ Attention Deficit / Hyperactivity Disorders (ADD/ADHD)
- ☐ Depression
- ☐ Anxiety
- ☐ Trauma-Related Symptoms
- ☐ OCD/Tics/Tourette's/Trichotillomania/Excoriation
- ☐ Other: _____

SERVICES REQUESTED (CHECK ALL THAT APPLY)

OHIP Funded Services:

- ☐ Virtual CBT for insomnia group
- ☐ Child, Adolescent, or Young Adult Psychiatry Consult for Diagnosis and Treatment Recommendations (<21 years of age, ongoing psychiatric care is not provided)
- ☐ Adult Psychiatry Consult for Diagnosis and Treatment Recommendations (≥21 years of age, ongoing psychiatric care is not provided)
- ☐ Medication Consult for Attention Deficit/Hyperactivity Disorder (Prior Psychoeducational Assessment has been completed)

Private Pay Services:

Might be covered by some private insurance plans

- ☐ Psychoeducational/ Learning Disabilities Assessment
- ☐ Ongoing Psychiatric Medication Management with Nurse Practitioner
- ☐ Psychodiagnostic Assessments with a Psychologist
- ☐ Autism Assessment
- ☐ ADHD & Executive Functioning Coaching
- ☐ Leadership and Career Coaching
- ☐ Individual, Couples or Family-Based Psychotherapy
- ☐ Occupational Therapy

_____
REFERRING PHYSICIAN/NURSE PRACTITIONER

_____
BILLING NO.

_____
PHONE

_____
FAX

_____
ADDRESS

_____

_____
EMAIL

I acknowledge that I am actively involved in the care of this patient and can act on the recommendations made by the clinicians from the Thrive Together clinic. Psychiatry recommendations will include a Medication Plan, where appropriate, specifying a medication recommendation and outlining a titration schedule. If there are questions about the Medication Plan or the patient's response to treatment at any time, I understand that I may consult with clinic physicians involved in the Medication Plan via e-consultation or telephone call. I also acknowledge that the Thrive Together clinic provides consultative care and does not assume ongoing care of this patient.

X _____
SIGNATURE

_____/_____/_____
DATE