

# COUNSELLING AND THERAPY REFERRAL FORM

Please note - We are unable to provide service for acute suicidal ideation; developmental delays and dual diagnosis; or if court mandated; or where primary/only concern is: ASD diagnosis; substance misuse; eating disorders; or child custody/access  
For intensive service referrals visit: [helpahead.ca](http://helpahead.ca); For a psychiatric consultation referral, complete Psychiatry Referral form

Date of referral (DD/MMM/YYYY):

PATIENT/CLIENT INFORMATION		
<b>Legal name</b> First name: _____ Last name: _____		<b>Chosen/Preferred name (if applicable)</b>
<b>Date of birth (DD/MMM/YYYY):</b>	<b>Pronouns:</b>	<b>Gender:</b>
<b>Health card number:</b>	<b>Expiration date (DD/MMM/YYYY):</b>	<b>Version code:</b>
<b>Patient/client address:</b> Address: _____ City: _____ Postal code: _____		
<b>Legal guardian(s)/caregiver(s)</b>		
Name: _____ Pronouns: _____	Relationship to client: _____	Tel #1: _____
Name: _____ Pronouns: _____	Relationship to client: _____	Tel #2: _____
<b>Is there a need for an interpreter?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, please specify which language: _____		

REFERRING PROVIDER INFORMATION		
<b>Name</b> First name: _____ Last name: _____		
<b>Role:</b>	<b>Organization:</b>	
<b>Billing number:</b>	<b>Telephone:</b>	<b>Fax:</b>
<b>Referring provider address:</b> Address: _____ City: _____ Postal code: _____		

REASON FOR REFERRAL
<b>Please indicate the primary reason for referral and if there are any risks and/or safety concerns</b> (specify current symptoms, presenting problems and history)
<b>Relevant mental health/medical/developmental history</b> (e.g. mental health diagnosis and history, family stressors relevant physical health issues, diagnosis of autism, intellectual delay, allergies, previous mental health assessments or other issues)
<b>Current medication - both psychiatric and non-psychiatric medication</b> (please list all medications, dose and frequency)

Please fax the completed GH-CCMH referral form to: Mental Health Access Program 416-874-6203

To help us provide the best care possible, please include relevant documents, such as discharge summaries and previous assessment and consultation reports, including psychiatric