REFERRAL FORM

Upon completion please Fax to 705-481-1925 or
email scanned copy or PDF to clinic@midlandtherapy.com
Only OHIP services MUST be completed by a Physician or Nurse Practitioner.

North Simcoe Therapy Network & Wellness Center

Please check all of the services that you or your client are interested in becoming involved in and we will contact them as soon as possible to coordinate.

Psychotherapy Services:

- ☐ Individual Psychotherapy
- ☐ Cognitive Behavioral Therapy
- ☐ DBT Skills Training (Adults/Children)
- ☐ Addictions Counselling and Referrals
- ☐ Indigenous Services (no cost/NIHB)
- ☐ Child and Youth Services (Individual and Group)

ADHD Clinic:

- ☐ Adult ADHD Psychiatric Consultation (OHIP covered)
- ☐ Adult ADHD Group (OHIP Covered)
- ☐ Adult ADHD Individual Psychotherapy/Counselling
- ☐ Adult ADHD Group (Fee for Service)
- ☐ Children's ADHD Services

Wellness Services:

- ☐ Registered Massage Therapy (Trauma Informed)
- ☐ Health and Fitness Classes
- ☐ Children's Yoga
- ☐ Adult Yoga for Anxiety
- ☐ Zumba for Anxiety
- ☐ Registered Nutritionist
- ☐ Music/Art Workshops
- ☐ Peer Support Counselling/Groups
- ☐ Court Support

Student Clinic:

- ☐ Low Cost Counselling
- ☐ Low Cost Groups

CLIENT/PATIENT INFORMATION

Name:_____
Date of birth:_____
Sex:_____
Gender/preferred pronouns:_____
Is your client/patient aware of this referral? YES or NO
If no, Please explain:_____
Phone:_____
Can messages be left at number provided? YES or NO
Email address:_____
Address:_____
Health card number:_____
Status card number:_____
Emergency Contact Name:_____
Phone number:_____
Relation:_____

REFERRAL SOURCE INFORMATION

Organization/Agency_____
Name:_____
Position:_____
Phone:_____
Fax: _____
Email:_____
Address:_____
Billing Number (If referred by NP or Physician):
_____

REASON FOR REFERRAL:
_____
_____
_____
_____

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Presenting Problems/Goals/treatments:

Substance use (Current Substance, amount, frequency of use ect...):

Risk Issues: If YES, When/details

- ☐ Suicide attempt/ideation _____
- ☐ Deliberate Self-Harm _____
- ☐ Violent Behavior _____
- ☐ Legal Involvement _____

Medications:

Name:_____ Dose/Frequency: _____
Response & Adverse Effects: _____

Name:_____ Dose/Frequency: _____
Response & Adverse Effects: _____

Name:_____ Dose/Frequency: _____
Response & Adverse Effects: _____

Agencies, Hospitals or Therapies Involved with the past two years:

Completed by: _____ Signature: _____ Date:_____