

NEW REFERRAL FORM

Dr. Sydnee Burgess, MD CCFP, GP-Psychotherapy

Referrals accepted from NP/MDs to Fax # 343-888-2500.

Phone: 343-988-0285

Email: info@mindfulwithsyd.ca

Website: Mindfulwithsyd.ca

Referring Provider Name: _____	Patient Name: _____
OHIP Billing #: _____	Address: _____
Phone Number: _____	DOB (dd/mm/yy): _____
Fax Number: _____	OHIP Card number: _____
Referring provider	OHIP Card Version Code: _____ Exp date : _____
Signature: _____	Contact phone Number: _____
	Patient's email address: _____

Current problem: _____

Pertinent History: _____

Psychotropic Medication List: _____

The following considerations help orient whether Dr Burgess' scope of practice, expertise and location can be helpful for your patient. Please mark with an "X" off the following if it applies to your patient:

- ☐ patients confirms they do not have access to private insurance from which they can access psychotherapy or counselling services
- ☐ patient does not have acute psychotic symptoms requiring stabilization (hallucinations or delusions that are not chronic, nor stable).
- ☐ Patient does not have a current need for diagnostic clarification of their mental health disorder
- ☐ patient self-identifies as having experienced discrimination based on their racial or ethnic identity.
- ☐ Can climb approximately 15 stairs (Dr Burgess' practice is at the top of a flight of stairs, for the time being)

Has this patient ever posed a risk of violence (eg, verbal or physical threats or assaults, staff harassment)?
Yes/No: _____. If yes, what was the nature of their behaviour in the past: _____

Patient (or legal guardian if under 18 years of age) consent for referral:

Signature: _____ Date: _____