NEW REFERRAL FORM

Dr. Sydnee Burgess, **MD CCFP, GP-Psychotherapy**
Referrals accepted from NPs/MDs to Fax # 343-888-2500.
Phone: 343-988-0285
Email: info@mindfulwithsyd.ca
Website: Mindfulwithsyd.ca

Referring Provider Name: _________________________	Patient Name: __________________________________
License #: ______________________________________	Address: ______________________________________
Phone Number: _________________________________	DOB (dd/mm/yy): ______________________________
Fax Number: ____________________________________	OHIP Card number: _____________________________
	OHIP Card Version Code: _____ Exp date :______
Referring provider	Contact phone Number: ______________________
Signature:_______________________________________	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: ____________________________________