



HEALING MINDS MENTAL HEALTH AND WELLNESS CENTRE INC.

3852, Finch Avenue East, Unit-302 Scarborough. ON. M1T3T9

Tel: +1 (416) 291-2944

Fax: +1(647)696-9336

Email: info@healingmindswellness.ca

MENTAL HEALTH INTERVENTION/PSYCHOTHERAPY- PATIENT REFERRAL FORM

CLIENT INFORMATION

Last Name: _____ First Name: _____

Gender: ☐ Male ☐ Female Date of Birth: _____

Telephone: _____ Client ID Number: _____

Address: _____

Email address: _____

DIAGNOSES

☐ Depression ☐ Anxiety ☐ PTSD (Post-Traumatic Stress Disorder)

☐ Panic Disorder ☐ Adjustment Disorder

☐ Other (DSM-IV or DSM-V Diagnosis) _____

LIST OF CURRENT MEDICATIONS, IF ANY:

REFERRING HEALTHCARE PRACTITIONER

Signature: _____ Date: _____

Full Name: _____

Designation: _____ College Registration #: _____

Clinic Address: _____

Tel: _____ Fax: _____ Email: _____

Please see the medical documents attached: ☐ Yes ☐ No

Official Stamp: