HEALING MINDS MENTAL HEALTH AND WELLNESS CENTRE INC.

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MENTAL HEALTH INTREVENTION/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 PRACTIONER

Signature:_____ Date:_____

Full Name:_____

Designation:_____ College Registration #:_____

Clinic Address:_____

Tel: _____ Fax: _____ Email:_____

Please see the medical documents attached: ☐ Yes ☐ No

Official Stamp: