ORCHID PSYCHOTHERAPY CLINIC

ADULT & ADOLESCENT MENTAL HEALTH CARE

Mailing Address: 1670 Bayview Ave, Ste 304, Toronto, ON M4G 3C2
Tel: 416-488-2838 Email: info@orchidclinic.ca

Please email completed referral form to: info@orchidclinic.ca, or forward to our office (mailing address above).

Adult ADHD Assessment/Consultation Referral Form

Information for Referring Physicians:

We provide ADHD/Mental Health Assessments for adults (18+) in the province of Ontario. Our assessment team consists of a Registered Psychologist and an Adult Psychiatrist. This is **NOT** a psycho-educational assessment and we do not investigate a possible learning disability, processing issues, or provide neuropsychological testing. The purpose of this assessment is to identify or rule out the presence of ADHD and co-morbid mental health conditions (eg: mood disorder, anxiety disorder, PTSD, etc).

An assessment report will be sent to the referring clinician with our clinical impression and treatment recommendations. Our clinic may be able to provide psychotherapy to your patient, however we generally do not follow patients for medical care beyond the consultation process. **Patients' care will be transferred back to the referring physician once medication has been optimized**.

Unfortunately, we do not accept referrals from WALK-IN CLINIC physicians unless this is the patients' primary physician.

<table>
<tr><td colspan="4">REFERRING PHYSICIAN INFORMATION: (or attach label)</td></tr>
<tr><td>Name:</td><td></td><td colspan="2">Date of Referral:</td></tr>
<tr><td rowspan="3">Practitioner Type:</td><td rowspan="3">Family Physician _____

Psychiatrist _____

Other (specify) _____</td><td>OHIP Billing #</td><td></td></tr>
<tr><td>Phone #:</td><td></td></tr>
<tr><td>Fax #:</td><td></td></tr>
<tr><td>Address:</td><td colspan="3"></td></tr>
<tr><td colspan="2">Are you the primary caregiver?</td><td colspan="2">Will you be monitoring patient/implementing treatment recommendations?</td></tr>
</table>

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PATIENT INFORMATION: (or attach label)			
Name		DOB:	
Home Address:		Gender:	
		Pronouns:	
Health Card #:		Version Code	
Phone #:		Alt Phone #:	
Email Address:			

Reason for referral (current symptoms and functioning, impairments, etc.)
Past psychiatric history (and other relevant history):
Neurological history:
Cardiac history:

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Family history of heart disease:		
Allergies:		
Other medical history:		
Current Medications & Previous Medication Trials:		
Patient's weight:	Patient's height:	Blood Pressure:

If patient is seeking medication treatment/recommendations, we require that recent bloodwork and ECG be completed.

ECG: Date: _____ (attach results)

Bloodwork: Date: _____(attach results)

(CBC, electrolytes, magnesium, calcium, phosphate, LFTs, creatinine, TSH, fasting blood sugar).

Other Notes:

Form Completed by: _____ Date: _____ CPSO#:_____