# GMD *PSYCHOTHERAPY* CENTRE

Tel: 905.597.2080 Fax: 365.525.2000 www.gmdclinic.ca

# SHORT WAIT TIMES

**Richmond Hill Location** □
330 Highway 7 East, Suite 511, Richmond Hill, ON, L4B 3P8

**North York Location** □
2221 Keele Str, Suite 301, North York, ON, M6M 3ZS

**Virtual** □

## FAX REFERRAL FORM TO 365.525.2000

**Date of Referral:**_____**Urgent: Yes**____ **No**____

**Patient Full Name:**_____

**Date of Birth :**_____/_____/_____

**Contact Number:**_____

**Email:**_____

**Address:**_____

**Referring Physician Name:**_____

**Tel:**_____ **Fax:**_____

**Address:**_____

**Signature:**_____

**Reason for referral (please check and describe below):**

□**Depression** □**Anxiety** □**Substance Abuse** □**Eating Disorder** □**Trauma/PTSD**

□**Executive Functioning** □**Relationship Issues** □**Grief** □**Self Esteem** □**Stress**

□**Other** _____

**If applicable, please include with the referral:** ☐ **Consultation Letters**

**Additional Comments:**_____

**Referring Physicians will be notified within 2 weeks of receipt and the patient will be notified of the appointment directly.**