Address: 3 Centre Street, Suite 201 Markham, ON L3P 3P9 Website: www.cnew.ca

Telephone: (905) 686-8110 Fax: (888) 540-8831 Email: info@cnew.ca

***Psychiatrist Referral Form***

***Client/Patient Information***

Last name: Click or tap here to enter text.

First name: Click or tap here to enter text.

Date of birth (yyyy/mm/dd): Click or tap to enter a date.

Date of referral (yyyy/mm/dd): Click or tap to enter a date.

Patient gender: Click or tap here to enter text.

Health card number + version code: Click or tap here to enter text.

Expiry date (yyyy/mm/dd): Click or tap to enter a date.

***Client/Patient contact information***

Parent/guardian name: Click or tap here to enter text.

Contact number: Click or tap here to enter text.

Address: Click or tap here to enter text.

Email: Click or tap here to enter text.

If you are able to advise, please confirm if confidential messages can be left at the

numbers provided above:

Yes No

|  |  |
| --- | --- |
| ***Reason for referral:*** |  |
| Diagnostic Assessment | Diagnostic Clarification |
| Treatment Recommendations | Ongoing Psychiatric care |
| Medication Review/Management | Other: Click or tap here to enter text. |

|  |  |  |  |
| --- | --- | --- | --- |
| ***Please indicate all medication(s) patient is currently taking.*** | | | |
| Medication name: | Dose/Frequency: | Duration: | Response: |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

If there are additional medications, please attach list with this referral.

|  |  |
| --- | --- |
| ***Safety/Risk Concerns:*** |  |
| Suicidal ideation | Self-harm |
| Aggression/violence risk | None reported |

***Referring source information – to be completed by physician:***

Last name: Click or tap here to enter text.

Stamp and/or signature:

First name: Click or tap here to enter text.

OHIP billing number: Click or tap here to enter text.

Practice/Clinic name: Click or tap here to enter text.

Address: Click or tap here to enter text.

Telephone number: Click or tap here to enter text.

Fax number: Click or tap here to enter text.

**Please fax completed referral to:**

Dr. Sinthu Sunthar

Centre for Neuropsychology and Emotional Wellness

Fax #: 888-540-8831