Psychotherapy & Psychodermatology Clinic

Body, Mind, Skin & Soul Clinic

Hummadi Healthcare **Fax: 905-823-9995**

Focus Practice Designation in Psychotherapy (No Negation for FHO/ FHT referring MDs)

Mental Health Patient Referral Form

PATIENT CONTACT INFORMATION

Last Name	First Name

Apt/Suite #	House/Bldg #	Road/Street	Town/City	Prov	Postal Code

Date of Birth (DD/MM/YYYY)	Gender	OHIP	Telephone (incl. area codes)
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PATIENT EMAIL	

MOST RESPONSIBLE PRACTITIONER (FAMILY PHYSICIAN, WALK-IN CLINIC PHYSICIAN, OR NURSE PRACTITIONER)

Last Name	First Name

Billing #

Office Telephone Number (including applicable area codes)	Fax Number

REFERRING CLINICIAN (if different from above)

Last Name	First Name

Referring Agency (if applicable)

PATIENT HISTORY

PHQ–9 Score ☐

Score must be <19

If question #9 on the PHQ-9 is positive (score of 1 or greater), note that acutely suicidal patients are not appropriate. Conduct a risk assessment and consider safety planning, and/or referral to services for patients of higher acuity.

Psychiatric Diagnosis:

- ❍ 300 Anxiety Disorder
- ❍ 311 Depressive Disorder
- ❍ 309 Adjustment Reaction
- ❍ 316 Psychological Factors Affecting Other Medical Conditions
- ❍ 300.4 Dysthymic Disorder
- ❍ Insomnia CBTI
- ❍ Other (specify ICD9 code): _____

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THIS SECTION MUST BE COMPLETED IN ORDER FOR THE REFERRAL TO BE PROCESSED

1. Is the individual:

Y / N Capable of engaging with and concentrating on CBT materials?
Y / N Experiencing acute mania or psychosis?
Y / N Actively suicidal or has tried to commit suicide in the past 6 months?
Y / N Diagnosed with a personality disorder?
Y / N At high risk to harm self or others?
Y / N Significantly misusing drugs or alcohol to the extent that it would impact engagement in CBT treatment?

☐ I confirm that this referral is not being sent directly from a hospital emergency department or in-patient psychiatric unit.

Please note that the primary healthcare practitioner always retains professional responsibility for the patient.

We offer coaching in English as well as Arabic; please identify the preferred language of your patient (E / A / both): _____

Patients cannot be referred without an identified MRP. A primary care provider must be available to provide therapeutic support if necessary. This program cannot provide emergency support.