



# REFERRAL FORM

After completing please fax to  
1•833•482•8999

## Steps to expedite your referral:

1. Please provide your patient's email address in the Patient Contact Information area
2. Instead of this form, consider using our online [e-Referral Form](#).

Patient Contact Information	
Last Name:	_____
First Name:	_____
DOB: (YYYY/MM/DD):	_____
Cell Phone:	_____
Alternate Phone:	_____
Address:	_____
City:	_____ Postal Code: _____
Email:	_____
Health Card No.:	_____ Version Code: _____
Is your patient rostered to an FHO? YES	
If your patient is rostered to an FHO we can expedite care with our Family Practice Intake and Medication Titration Team but you would need to temporarily de-roster your patient.	
Do you choose to temporarily de-roster? YES	

1. Are there current court/medical legal and/or custody matters? YES	NO	
2. Previous Diagnosis: YES	NO	
If YES, identify diagnosis:		
3. Medication and Dosage (past and current):		
Medication	Dosage	Date

**Psychiatric/Medical History:**  
Please attach all relevant documents, assessment reports, and labs)

Current Vitals	
Resting Blood Pressure:	
Resting Heart Rate:	
Height (cm):	
Weight (kg):	

Most services can be provided through secure video sessions across Ontario. Most of our specialized multidisciplinary services and integrated treatments involve allied health professionals not covered by OHIP. Fees may be covered by private insurance.

**Reason for Referral (please indicate all that apply):**

*All our services are for all ages.*

**Assessments:**

- Attention Deficit/Hyperactivity Disorders (ADD/ADHD)
- Psychoeducational / Learning Disabilities and Disorders
- Autism Diagnostic Assessment
- Tic Disorder and Tourette Syndrome Assessment and Consultation (Fully OHIP Covered)
- Giftedness
- Early Years Assessment (3.5 - 6 years of age)

**Therapies:**

- ADHD (e.g. Coaching, CBT)
- Learning Disabilities (e.g. evidence-based tutoring)
- Anxiety, Depression (e.g. CBT)
- Tic Disorders and Tourette Syndrome (e.g. Comprehensive Behavioural Intervention for TICS)
- Family Conflict (e.g. Parenting Strategies/Support)
- Emotional and Behavioural Regulation (e.g. DBT)
- Occupational Therapy
- Career Coaching
- Dietitian Service

**Physician Information**

Referring Physician/Nurse Practitioner: \_\_\_\_\_ Billing No.: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

I acknowledge that I am actively involved in the care of this patient and can act on the recommendations made by the Possibilities Clinic. Clinic recommendations will include a Medication Plan, where appropriate, specifying a recommendation medication and outlining a titration schedule. If I have questions about the Medication Plan or the patient's response to treatment at any time, I understand that I may consult with with clinic physicians involved in the Medication plan via e-consultation or telephone call. I also acknowledge that the Possibilities Clinic provides consultative care and does not assume ongoing care of this patient.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please type or sign name