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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):	

Toll Free: 1•833•482•5558 Fax: 1•833•482•8999 possibilitiesclinic.com

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Patient Name: _____

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.

Assessment:

- ☐ Attention Deficit/Hyperactivity Disorders (ADD/ADHD)
- ☐ Psychoeducational / Learning Disabilities and Disorders
- ☐ Autism
- ☐ Giftedness
- ☐ Tic Disorder and Tourette Syndrome

Coaching/Therapy:

- ☐ ADHD Coaching
- ☐ Executive Functioning Coaching
- ☐ Leadership and Career Coaching
- ☐ Anxiety Therapy (e.g. CBT)
- ☐ Depression Therapy (e.g. ACT, CBT)
- ☐ Tic Disorders and Tourette Syndrome (e.g. CBIT)
- ☐ Parenting Strategies/Support
- ☐ Emotional and Behavioural Regulation (e.g. DBT, Zones of Regulation)
- ☐ Occupational Therapy
- ☐ Couples Counseling
- ☐ 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

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