Centre for Integrative Mental Health

Specialists in Integrative Treatments for ADHD and Associated Conditions

REFERRAL FORM

After completing please fax to:

905-580-9999

We do not accept referrals for court purposes; and/or cases with unresolved custody/access.

Date of Referral: _____

Patient Contact Information:

Patient Name:

_____

DOB:(YYYY/MM/DD): _____ _____ ____ Sex: M/F/other

Health Card No. _____ Version Code _____

Phone: _____ Alt. Phone: _____

Address: _____

_____

Email: _____

Physician Information:

Referring Physician:

_____

Billing No. _____

Phone: _____

Fax: _____

Address: _____

_____

Email: _____

Reason for Referral:

OHIP Services:

- ☐ Comprehensive assessment of Attention: For ADHD and associated conditions - including cognitive testing *Psychometric fee applies (17 years and under)
- ☐ Comprehensive assessment of Attention: For Adult ADHD and associated conditions - including cognitive testing *Psychometric Fee applies (18 years plus)

Non-OHIP Services: **Fees vary with service.**

- ☐ Cognitive Behavioural Therapy (CBT) for Anxiety
- ☐ Cognitive Behavioural Therapy (CBT) for Depression
- ☐ Cognitive Behavioural Therapy (CBT) for Adult ADHD
- ☐ Parent Management Training for Child/Teen Behavioural Issues
- ☐ Executive Functions Therapy and Strategies
- ☐ Mindfulness Strategies
- ☐ Social Skills Therapy for Kids
- ☐ Self-esteem Therapy for Kids
- ☐ Anger Management Therapy for Kids/Teens
- ☐ Family Therapy
- ☐ Naturopathic Assessment

Reason for Referral ****MUST BE COMPLETED**

Pertinent Psychiatric History (attach relevant reports/assessments)

Pertinent Medical History: (attach all relevant documents and lab reports)

Medication & Doses:

I acknowledge that I am actively involved in the care of this patient and can act on the recommendations made by the Centre for Integrative Mental Health.

Referring Doctor's Signature: _____ **Date:** _____