Patient Referral Form

Date of referral _____

Fax completed form to 1 289 203-1178

☐ Please confirm that the referrer/Primary Care Provider is aware that some of our services might contribute to outside use.

Patient information

Last name _____ First name _____

Preferred name _____ OHIP # _____ Version Code _____

Pronouns _____ DOB (mm/dd/yyyy) _____

Patients phone # _____ Alternative phone # _____

Can we leave a message on patient's voicemail? ☐ Yes ☐ No

Email address* _____

**Client will be contacted via email to arrange initial appointment*

Patient considerations:

☐ Cognitive impairment ☐ Sight impairment ☐ Language barrier *(specify language needed)*

☐ Hearing impairment ☐ Aged 65+ household ☐ Other

Does the patient have extended health benefits? ☐ Yes ☐ No ☐ Unsure

Reason for referral

☐ Anxiety	☐ Anger	☐ Eating Disorders
☐ Depression	☐ Stress	☐ Coping with medical illness
☐ Insomnia	☐ Phobias	☐ LGBTQIA+ Health
☐ OCD	☐ Chronic Pain	☐ Substance Abuse
☐ Self-Esteem	☐ ADHD	☐ Postpartum depression
☐ Bereavement	☐ Social Anxiety	☐ Smoking Cessation
☐ Perfectionism	☐ Relationships	☐ Illness Anxiety Disorder

Other _____

The TeleCBT OHIP Scope of Practice does not include the following challenges at this time: bipolar disorder, borderline personality disorder (BPD), obsessive-compulsive disorder (OCD), psychosis (e.g., schizophrenia), trauma and/or post-traumatic stress disorder (PTSD), suicidal ideation (suicidal thoughts with a plan and means), suicide attempts within the past year, and mental health challenges for which hospitalization was required within the past year.

Referrer/Primary Care Provider

Additional comments

Convenient, confidential online counseling. We can help.

If you have questions, please contact us: info@telecbt.ca www.telecbt.ca

DISCLAIMER: TeleCBT is not appropriate for crisis counseling.