Referral/Consultation Form

PLEASE READ CAREFULLY BEFORE COMPLETING/SUBMITTING FORM

Please review the following information with your patient:

Patients will be contacted to set up a 45 minute, virtual intake session with our team. Effective November 1st, 2023 there will be a $110 fee for intake appointments. Once the intake is complete and a patient is deemed appropriate for our service they will be added to our wait-list until they are matched with a physician.

☐ **I confirm that the fee associated with the intake has been reviewed with the patient.**

As of December 1st, 2022 OHIP now requires patients to have their first visit in-person to establish a patient-physcian relationship. Patients must be wiling to visit one of our offices located in Toronto, Markham, Burlington, London, Kitchener/Waterloo or Ottawa for these visits. There are some alternatives under special circumstances and that can be discussed during the patients intake appointment.

TeleCBT does not offer psychiatric assessments/diagnosis or provide patients with medication management.

Disclaimer:
TeleCBT is not appropriate for individuals experiencing crisis or in need of urgent care.
Patients experiencing a mental health or addiction emergency should be directed to the nearest emergency department.

TeleCBT OHIP Scope of Practice:
At this time the following challenges are not included: bipolar disorder, borderline personality disorder (BPD), 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.

REFERRAL/CONSULATION PROCESS

Please ensure your patient is aware of this referral. Our intake staff will make **two** attempts to reach the patient via email and leave voice mail messages; if consent is indicated. PLEASE NOTE: Our staff may be calling from a blocked or unknown number. If the patient is booked OR we are unable to reach the patient, the referral source will be notified by fax.

All referrals are reviewed by our team prior to contacting patients. If the referral is outside the TeleCBT Scope of Practice as outlined above the patient **will not** be contacted and the referral source will be notified by fax and the referral will be inactivated.

How to submit a referral:

- Review the above information with your patient to ensure expectations are aligned
- Fax the completed form to 289-203-1178
- Please Note: All fields marked with * are mandatory and should not be left blank. If a mandatory field is not applicable, please enter ‘n/a’.
- Fax each referral form individually

Referral/Consultation 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

Is the patient interest in one-on-one therapy or groups? ☐ One-on-One ☐ Groups ☐ Both

Reason for referral

☐ Anxiety	☐ Anger	☐ Grief Therapy
☐ Depression	☐ Stress	☐ Coping with medical illness
☐ Insomnia	☐ Phobias	☐ LGBTQIA+ Health
☐ OCD	☐ Chronic Pain	☐ Substance Use Disorder
☐ 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), 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

Name

OHIP Billing #

Address

Phone #

Fax #

Signature

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.