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. 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.

As of December 1st, 2022 OHIP requires patients to have their first visit in-person to establish a patient-physician 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 # ______________________

NOTE: Client will be contacted via phone/email to arrange initial appointment.

Email address* ______________________

Patient considerations:

Cognitive impairment | Sight impairment | Other:

Hearing impairment | Aged 65+ household

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
OCD	Phobias	Postpartum Depression
Self-Esteem	Chronic Pain	Illness Anxiety Disorder
Bereavement	Social Anxiety	
Perfectionism	Relationships	

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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.