TORONTO MENTAL HEALTH & WELL - BEING SERVICES

Counseling and Psychotherapy Services
Phone: 647-568-1019
Fax: 416-519-1127
Email: info@tmhws.com
Web: www.tmhws.com

REFERRAL FORM

Fax to 416-519-1127

This form is to be completed by the Referrer/Agency Department. THIS FORM IS CONFIDENTIAL and must be agreed upon by the client that the details on this referral form are accurate. Please print form. Fill out and fax to the number indicated above.

Patient Details

First Name:_____ Last Name: _____
Date of Birth:_____ Sex: Male ☐ Female ☐
Address:_____
Preferred Contact Number: Mobile_____Other _____
IFHP- UCI# (if applicable):_____
Language Spoken at Home:_____ Interpreter Required: Yes ☐ No ☐

Reasons for Referral

- Anxiety (general)/ Stress
- Anxiety about the future (work, education, pandemic etc.)
- Anxiety around legal matters
- Body Image Issues
- Concerns around health
- Coping with immigration issues
- End of life
- Family issues
- Relationship difficulties
- Issues around decision making
- Low confidence and self-esteem
- Low mood
- Managing nausea
- Pain
- Problems with anger
- Problems with food or eating
- Post traumatic stress disorder signs
- Problems with sleep
- Trauma
- Culture shock

Please Provide Details:

Required Services

- Individual counselling
- Couple's counselling
- Counselling for refugees
- Trauma counselling
- Counselling for newcomers
- Others

Referring Services

Family Doctor / Nurse Practitioner / Psychiatrist

Name:
Provider Number:
Address:
Telephone Number:
Fax Number:

Practice stamp (if available)

Provider's Signature:_____Date:_____