

Asian Community Psychiatric Clinic

Ethno-specific Psychiatric Consultations

c/o Hong Fook Mental Health Association

130 Dundas St. W., 3rd Floor, Toronto M5G 1C3

Tel: (416) 493-4242 Fax: (416) 595-6332

REFERRAL FORM

SOURCE OF REFERRAL: MD Nurse Practitioner Service provider, specify _____ Others, specify _____

Last Name _____ First Name _____ Physician's Billing # _____

Address _____ Postal Code _____

Telephone _____ Fax _____ E-mail _____

PATIENT INFORMATION:

Last Name _____ First Name _____

DOB yy ____ /mm ____ /dd ____ Sex M F Other

Health Card # _____ Version Code _____ Expiry Date _____

Address _____ Postal Code _____

Telephone (H) _____ (B) _____ (C) _____ E-mail _____

Preferred Language: Cambodian Cantonese English Korean Mandarin Vietnamese

Reasons for Referral (e.g. depression):

Type of Referral:

- Consultation only
- Consultation with short term intervention (referrer will provide follow-up after)
- Consultation with ongoing treatment

Past Psychiatric Treatment (please include previous psychiatric consultation notes, admission/discharge summaries from hospital):

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Medical History: (include medical conditions, surgeries, hospitalizations, etc.)

Current Medications:

Allergies:

Psychosocial needs requiring early attention (e.g. financial, housing, etc):

Additional information (e.g. self-harm, aggression, substance use, legal matters, other services involved, etc):

Client consent:

I have obtained client consent to be contacted by the Asian Clinic/Hong Fook Mental Health Association for services.

Signature of Referrer: _____

Date: _____

OFFICE USE ONLY

Hong Fook Worker involved (Name and Position): _____

Date Referral Received: _____

Referral accepted date: _____

Referral declined date: _____

First appointment Date and Time: _____

Downtown

Scarborough

With Dr. _____

No show

Cancellation by patient