Asian Community Psychiatric Clinic

Ethno-specific Psychiatric Consultations

c/o Hong Fook Mental Health Association

407 Huron Street, 3rd Floor, ON M5S 2G5

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

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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