Asian Community Psychiatric Clinic

Ethno-specific Psychiatric Consultations

c/o Hong Fook Mental Health Association

407 Huron Street, 3rd Floor, Toronto, 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
- ❑ For Collaborative care

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

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Name of Patient:

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