WELL Mental Health & Wellness

THERAPY REFERRAL FORM

PATIENT INFORMATION

First Name: _____

Last Name: _____

Date of Birth: ____ / ____ / ____ Province: _____

Phone Number: _____ Email: _____

Preferred Language: _____

Gender:
- ☐ Female
- ☐ Non-binary
- ☐ Trans Woman
- ☐ Androgynous
- ☐ Other
- ☐ Male
- ☐ Gender fluid
- ☐ Trans Man
- ☐ Two Spirited

Presenting Issues: _____

Diagnosis (if known): _____

Current Medications: _____

REFERRING PROVIDER INFORMATION

Full Name: _____ Clinic Name: _____

Select one of the following:
- ☐ Family Physician
- ☐ Psychiatrist
- ☐ Other
- ☐ Nurse Practitioner
- ☐ Methadone/Suboxone Provider

Address: _____

City: _____ Province: _____

Postal Code: _____

1 King St. W I Suite 4800 - 149
Toronto, ON I M5H 1A1
Fax: 416 232 0849
Email: wellclientcare@focusmw.com