PSYCHIATRY/COUNSELLING REFERRAL FORM

PLEASE FAX COMPLETED REFERRAL TO:

Health and Wellness 6 H U Y L F H V, Western University
Thames Hall, Room 2170 x London, Ontario, N6A 3K7
Telephone: (519) 661-3030 x Fax: (226) 636-6118

Date of Referral: _____

Referring Physician:	Name: Address: Telephone #: Email:	Billing #: Fax #:
Patient Information:	Name: Address: Health Card #: Date of Birth:	Student #:
Reason for Referral:		
History and Symptoms		
Medications: Dose, duration, response		

Current alcohol/substance use (circle) None Yes ± Quantity_____	Past treatment for alcohol/substance use (circle) None Yes ± Describe:_____
Does this patient have any medical illnesses? Describe:	3atient R F F X S D W L R QH DOVR K DV V? : R U N L Q J I X O O W L P H R U S D U W W L P H 1 R W Z R U N L Q J 8 Q D E O H W R Z R U N
Does this patient have another psychiatrist:	Is the psychiatrist aware of this referral? No Yes
Is this patient involved in current/pending civil/criminal litigation?	Is the patient involved in current/pending compensation/insurance claims? No Yes: specify_____