BeWell Health Clinic

55 York Street, Suite 201
Toronto, ON, M5J 1R7
Tel: 647-715-3900 Fax: 416-599-9001
Email: info@bewellto.com

# Out-Patient Consultation Referral

**Please Note:** Patients will be seen by psychiatrist for a **one-time consultation** based on acceptance of the referral. **This referral will be accepted on the basis that the referring physician agrees to accept patient care once psychiatric consultation is completed**

**BeWell Health Clinic** will make **two** attempts to contact the patient and leave two voicemails when consent is provided. If the patient cannot be reached, the referring provider will be notified. **If referral is not accepted referring office is expected to notify patient directly.**

Referring to: Dr. Mandeep Singh ☐ Dr. Samir Gandhi ☐ First Available ☐

Date:

**PATIENT INFORMATION**

Last Name: First Name:
Address: Postal Code:
Date of Birth (dd/mm/yyyy): OHIP # : Version Code:
Phone Number: Email Address:
Can we leave a voicemail? YES ☐ NO ☐ Sex:

**REFERRING PHYSICIAN INFORMATION**

Referring Physician Name: OHIP Billing Number:
Clinic Address:
Clinic Phone Number:
Clinic Fax Number:
Does referring physician or family doctor agree to implement/monitor recommendations and provide ongoing follow-up? YES ☐ NO ☐

**REASON FOR REFERRAL**

Details of Referral (including target symptoms and goals of treatment):

| |
|---|
| |

Does this patient currently have a psychiatrist? YES ☐ NO ☐
*** Please note if this patient is currently being followed by a psychiatrist, the referral will not be accepted**

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## PAST PSYCHIATRIC HISTORY (Last 2 Years)

Hospitalization -

Mental Health Therapies -

## PAST MEDICAL HISTORY

## CURRENT MEDICATION

## SUBSTANCE USE HISTORY

**Additional Information:** _____

_____

_____

**If this form is not completed in its entirety it will not be accepted. Please note the current wait time is 2-3 months on average.**