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Consultation Request Form

Referring Provider: OHIP #: Address: Phone #: Fax #:	<p style="text-align: center;"><u>**Please Acknowledge**</u></p> <p>I acknowledge that (please check):</p> <ul style="list-style-type: none"> <input type="checkbox"/> West End Recovery does not provide primary care <input type="checkbox"/> The patient is aware that some services are not OHIP-covered (ie. psychotherapy) <input type="checkbox"/> The patient is not in a current state of crisis requiring involuntary hospital admission at the time of referral
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Patient Name: Health Card #: DOB (MM/DD/YY): Address: Phone #: E-mail:	<p style="text-align: center;"><u>Requested Service</u></p> <p>Check all that apply & specify details below:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Addiction Medicine <input type="checkbox"/> Psychiatry <input type="checkbox"/> Psychotherapy <input type="checkbox"/> Chronic pain
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<p style="text-align: center;"><u>Reason(s) For Referral</u></p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	<p style="text-align: center;"><u>Current Medications:</u></p>
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Referring provider signature indicates acknowledgement that (i) your patient consents to protected information being shared with West End Recovery, (ii) consultation is not guaranteed, pending referral review, (iii) incomplete referrals will be rejected, and (iv) all items contained in this referral form are true to the best of the referring provider's knowledge.

 Signature (referring provider)

 Date