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Etobicoke, ON, Canada
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Consultation Request Form

Referring Provider: **OHIP #:** **Address:** **Phone #:** **Fax #:**	****Please Acknowledge**** I acknowledge that (please check): ☐ West End Recovery does ***not*** provide primary care ☐ The patient is aware that some services are ***not*** OHIP-covered (ie. psychotherapy) ☐ The patient is ***not*** in a current state of crisis requiring involuntary hospital admission at the time of referral
Patient Name: **Health Card #:** **DOB (MM/DD/YY):** **Address:** **Phone #:** **E-mail:**	**Requested Service** Check all that apply & specify details below: ☐ Addiction Medicine ☐ ~~Psychiatry~~ ☐ ~~Psychotherapy~~ ☐ ~~Chronic pain~~

Reason(s) For Referral	**Current Medications:**

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