PSYCHIATRY/COUNSELLING REFERRAL FORM

PLEASE FAX COMPLETED REFERRAL TO:

Health and Wellness Services, Western University
Thames Hall, Room 2170 • London, Ontario, N6A 3K7
Telephone: (519) 661-3030 • **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:	**Patient occupational status?** (circle) Working: full-time or part-time Not working/Unable to work
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: specifiy_____