Referral Form

The Healing Institute at Forbidden Plateau

Date of Referral:

Patient Demographic Information:

Patient Name:	Gender:
Date of Birth:	Health Care No.:
Address:	City:
Province/State:	Postal/Zip Code:
Email Address:	Home Phone:
Mobile Phone:	Work Phone:
Current Height:	Current Weight:
General Practitioner (GP):	GP Clinic:
GP Phone:	GP Fax:
Allergies:	
Employer:	Occupation:
Treatment Funder:	
Accommodation Type: ◯ Semi-Private	◯ Private

Referrer Information:

Referrer Name:	
Health Care Discipline:	
Physician/NP Billing No. (if applicable):	
Clinic/Agency:	
Address:	City:
Province/State:	Postal/zip Code:
Country:	Email:
Phone:	Fax:
Will you be providing care post discharge? ◯ Yes	◯ No

Post Discharge Community Care Provider:

Name:	Title:
Address:	City:
Province/State:	Postal/Zip Code:
Country:	Email:
Phone:	Fax:

Primary Reason for Referral:

Patient Diagnosis: Check all that apply and indicate which is the primary concern.

In the last 12 months	Primary Concern	Diagnosis
☐	☐	Drug and/or alcohol addiction
☐	☐	Bipolar Disorder
☐	☐	Acute or Chronic Psychosis
☐	☐	PTSD or Trauma Related Disorders
☐	☐	Anxiety Disorder
☐	☐	Major Depressive Disorder
☐	☐	Dissociative Disorder
☐	☐	Eating Disorder
☐	☐	Dementia
☐	☐	ADHD
☐	☐	OCD
☐	☐	Autism or Autism Spectrum Disorder
☐	☐	Chronic Pain
☐	☐	Cognitive Disorder
☐	☐	Schizophrenia
☐	☐	Personality Disorder
☐	☐	**Other:** *Please describe*

Current Safety Risk:

- ☐ Current active or passive suicidal thoughts
- ☐ History of suicide attempts
- ☐ Currently self-harming
- ☐ Current legal issues
- ☐ Past legal issues
- ☐ Current homicidal thoughts
- ☐ Dissociation
- ☐ Flashbacks
- ☐ History of violence towards others and/or property
- ☐ Risk of falling/history of recent falls

If any safety risks are identified above, please explain further:

Medical History: please note all applicable conditions (e/g/ hypertension, diabetes, etc.) and any other relevant information.

Current Medications: if list is not being attached to this Referral Form

Medication	Dosage	Frequency	Reason for Use

Addiction History: If the client does not have any current substance use problems, please skip this section.

Substance	Amount Per Day	Years of Use

Has the patient ever experienced severe withdrawal symptoms from alcohol or drugs?
◯ Yes ◯ No If yes, describe:

Thank you for completing this Referral Form.

All referral forms and relevant information should be emailed to:
info@thehealinginstitute.ca

We will contact you once we have reviewed the referral form. If you have any questions, please contact 1-877-774-3843 or info@thehealinginsitute.ca