

Referral Form

The Healing Institute at Taylor Bay

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: (If self referred, please skip this section)

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: (Please include, previous treatment attempts in this section)

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: <i>Please describe</i>

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:

aidan@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 aidan@thehealinginstitute.ca