Robin Beardsley MD CCFP
from striving **to thriving**

robinbeardsleymd.ca

Referral Form for Dr. Robin Beardsley for Psychotherapy

Instructions: Print, complete this form and fax to 613-595-1600. Please contact me directly if you have any questions. **NOTE: * (indicates required fields)**

Dr. Beardsley **will not** offer services for:

- CAS, Court or Forensic Assessments
- Treatment of Primary Drug/Alcohol addictions.
- Psychosis/Schizophrenia/Behavioural Problems

Patient Information

Date of Referral: _____

First Name:* _____ Last Name:*_____

Address: _____ Apt#: _____

City: _____ Province: _____

Postal Code: _____ Email: _____

Phone w/ extension if applicable:* _____ Is your phone textable? Yes____ No____

Health Card:* _____ Version Code (if applicable): _____

Expiry Date:*_ _____ Province (Health Card):*_____

Date of Birth:* _____ Occupation: _____

Referring Physician

Name: _____ OHIP Billing #:_____

Address: _____ Apt#: _____

City: _____ Province: _____

Postal Code: _____ Email: _____

Phone w/ext. if applicable: _____ Fax: _____

Are you a: Family Physician_____ Psychiatrist_____ Other: _____

Is the patient aware of and agreement with this referral? YES_____ NO_____

Is the patient aware they will have to make contact once this referral is made? YES_____ NO_____

Reason for Referral

Describe your sense of the issue(s) as specifically as possible:

Are there any known factors or barriers, complicating possible outcomes?

Medications

Current Medication	Dose	Frequency	Date Started

Past Medications	Dose	Frequency	Dates of Use

Other Relevant Information: (attach previous consultations where available)

Current Substance Use: YES_____ NO_____ If yes, please describe:

Current Legal Issues: YES_____ NO_____ If yes, please describe:

Current / Pending Compensation / Insurance Claims: YES_____ NO_____ If yes, please describe:

It is the responsibility of the referring physician to complete the insurance forms. Dr. Beardsley will provide a summary of work if requested.

Past Psychiatric Treatment / Hospitalizations: YES_____ NO_____ If yes, please describe:

Family History of Psychiatric Illness

History of Medical Illness:

Additional Information / Comments:

Signature: _____ Date: _____