**Paris Mind Clinic**
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## Patient Referral Form for Psychotherapy

***IMPORTANT: This referral form must be dated and signed to be accepted.**

| | | | |
|---|---|---|---|
| Referring Physician (MD/NP): | | Patient Name: | |
| Referring Clinic | | Sex: | |
| ***Date of Referral:** | | Health Card No.: | |
| Consultation: | Psychotherapy | Date of Birth: | |
| Status: | - | Phone: | |
| Phone: | | Work Phone: | |
| Fax: | | Email: | |
| Email: | | Address: | |
| Address: | | | |
| ***Signature:** | | | |

Reason for Consultation:

| | | | | |
|---|---|---|---|---|
| ☐ Depression | ☐ Anxiety | ☐ Panic Disorder | ☐ Adjustment Disorder | ☐ PTSD |
| ☐ Mood Disorder | ☐ Phobias | ☐ Acute Stress | ☐ Social anxiety | ☐ OCD |
| ☐ Traumatic Grief | ☐ ADHD | ☐ Other (Please specify the DSM-5 diagnosis) | | |

Pertinent Clinical Information:

Signifiant Concurrent Problems:

Current Medications:

**"Incomplete referrals (missing date, signature and name) cannot be processed. Please ensure all fields are filled."**