virtualclinic

PsychotherapyMatters.com

Psychiatric Consultation Request

Tel: 1-800-254-1235 Fax: 647-699-9812

Our service links therapists, family physicians, and psychiatrists. Therapists charge a fee (reimbursable by insurance) for assessment. They are linked to psychiatrists who provide telepsychiatry consultations (fully covered by the OTN). **Please inform your patient that we will call them directly to schedule an appointment.**

Patient Information

Name: _____ Date of Birth: __ __ __ __ / __ __ / __ __
(first name) (last name) yyyy mm dd

Health Card #: __ __ __ __ __ __ __ __ __ __ VC: __ __ Phone: __ __ __ - __ __ __ - __ __ __ __

Address: _____ Postal Code: __ __ __ __ __ __
(street number, street name, city, province)

Email Address: _____

Referring Physician

Referral from Dr. _____ MD Billing #: __ __ __ __ __ __
(first name) (last name)

Fax: __ __ __ - __ __ __ - __ __ __ __ (Please print clearly.)

Check all that apply: ☐ Above MD is Patient's PCP ☐ Rostered Patient ☐ FIT / FHO

Reasons for Referral

☐ Medication ☐ Diagnosis ☐ Psychotherapy ☐ Other

Current Medications

Doctor/Clinic Stamp

MD Signature

Date:

Fax: 647-699-9812 **Email: virtualclinic@psychotherapymatters.com**

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