



PSYCHIATRY/COUNSELLING REFERRAL FORM

PLEASE FAX COMPLETED REFERRAL TO:
 Health and Wellness 6 H U Y L F H V, Western University
 Thames Hall, Room 2170 x London, Ontario, N6A 3K7
 Telephone: (519) 661-3030 x Fax: (226) 636-6118

Date of Referral: _____

Referring
Physician:

Name:	Billing #:
Address	
Telephone #:	Fax #:
Email:	

Patient
Information:

Name:	Student #:
Address:	
Health Card #:	
Date of Birth:	

Reason for
Referral:

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History and
Symptoms

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Medications:

Dose, duration, response

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Current alcohol/substance use (circle) None Yes ±Quantity _____	Past treatment for alcohol/substance use(circle) None Yes ±Describe: _____
Does this patient have any medical illnesses? Describe:	3atient R F F X S D W L R Q P L O J F O M D W X V? : R U N L Q J I X O O W L P H R U S D U W W L P H 1 R W Z R U N L Q J 8 Q D E O H W R Z R U N
Does this patient have another psychiatrist:	Is the psychiatrist aware of this referral? No Yes
Is this patient involved in current/pending civil/criminal litigation?	Is the patient involved in current/pending compensation/insurance claims? No Yes: specify _____