PSYCHIATRY/COUNSELLING REFERRAL FORM

PLEASE FAX COMPLETED REFERRAL TO:

Student Health Services, Western University
University Community Centre, Room 11 • London, Ontario, N6A 3K7
Telephone: (519) 661-3030 • **Fax: (519) 661-3380**

Date of Referral:____

Referring Physician: Name, address, telephone, fax,	
	BILLING NUMBER:
Patient Information: Name, address, phone, Health card number, DOB	
Reason for Referral:	
History and Symptoms:	
Medications: Dose, duration, response	

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:	**Is the patient partially/fully disable from working?** No Yes: specify______________________________
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: specifiy______________________________