Asian Initiative in Mental Health
Early Intervention in Psychosis

Community Mental Health
Toronto Western Hospital
399 Bathurst St.
9 East Wing
Toronto, Ontario M5T 2S8
Telephone: (416) 603-5349
Facsimile: (416) 603-5661

REFERRAL FORM

CLIENT INFORMATION:

First Name: ________________ Last Name: __________________Gender: Male Female

Age: ______Date of Birth: (mm/dd/yy)______________Health Card Number: _____________

Address:____

Telephone number: Home______________ Cell______________ Business ________________

Mother Tongue:________________Dialect:_____________Preferred Language_____________

Does client speak English: Little Some Fluent

Status: Canadian Citizenship Permanent Resident Others

Psychiatrist's Name:_____________________________ Phone Number: _________________

Address:____

Family Physician's Name: ________________________ Phone Number: __________________

Address:____

Brief description of history of present illness: (Please forward recent lab. Results and relevant reports)

Past psychiatric history: (including previous psychiatrists, medications, hospitalizations,etc.)

Past medical history: (including medical conditions, surgeries, hospitalizations, etc.)

Current Medications:

Allergies:

Psychotic symptoms checklist:

Does client experience following symptoms? (please put check marks in the box if yes)

Hallucinations (e.g., hearing or seeing something others can not hear or see)

Delusions (e.g., suspicious, followed or persecuted by others, etc.)

Disorganized speech or behavior

Socially withdraw

Others:

Additional Information: (please put check marks in the box if yes)

Criminal/Legal Issues Pending:

Chemical Dependency:

History of Self Harm:

History of Aggression:

REFERRAL RESOURCE INFORMATION (Please complete it if not a self-referral)

Referrer's Name:____________Phone Number:____________Agency:____________________

Address:____

Physician's Billing (if referrer is a physician) ____

Tel#:______________ Cell#______________ Business# _____________Fax#:______________

Relationship to Client:_____________________ Date of Referral:________________________

Thank you for filling out this referral form!

If you have any questions, please contact us at (416) 603-5071.

Please return the completed referral form to us by fax at (416) 603-5661 or mail it to:

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