家和專業輔導中心
CHINESE FAMILY SERVICES OF ONTARIO
229-3330 Midland Ave, Scarborough ON M1V 5E7 T: 416-979-8299 F: 416979-2743 E: info@chinesefamilyso.com

CONFIDENTIAL

SERVICE PROVIDER REFERRAL REQUEST FORM

REFERRER'S INFORMATION: ☐ GP ☐ Psychiatrist ☐ Other (please specify): ____________________

Agency / Organization: ____________ Referrer's Name: ______________________

Contact number: ______________ Fax: ______________ E-mail: ______________

PATIENT'S INFORMATION: (Is patient aware of this referral? ☐ Yes ☐ No)

Last Name: __________________ First Name: ______________________

Date of Birth (YYYY/MM/DD): ______________ Gender: ☐ Male ☐ Female

Home #: ____________ Mobile / Work #: ____________ E-mail: ______________

Language: ☐ English ☐ Mandarin ☐ Cantonese ☐ Vietnamese ☐ Other: ______________

Reason for Referral: ______________________________________

Diagnosis: ☐ Depression (Mild / Moderate) ☐ Anxiety (Generalized / Social / Phobia)
☐ PTSD ☐ OCD ☐ Other: ______________________

Prescription(s) / Active Medication(s): ______________________________

NOTE TO REFERRER

Complete this form and fax to 416-979-2743 or e-mail info@chinesefamilyso.com to refer patients for counselling at Chinese Family Services of Ontario. For mental health psychotherapy, only patients with **common, mild to moderate mental health issues** and who are **following all necessary medical management** will benefit from our services.

Referrer's Signature: ______________________ Date: ______________________

NOTE TO PATIENT: Consent to Contact

By providing my personal information, I, ____________ (patient's name) voluntarily consent and authorize **Chinese Family Services of Ontario** to contact me by phone or email. If the Chinese Family Services of Ontario is not able to reach me after three attempts within one month, this form would be destroyed and I would need to contact the Chinese Family Services of Ontario myself if I require services from them.

I would like the Chinese Family Services of Ontario to contact me by (select all that are applicable):

☐ Home Phone Leave voice message: ☐ Yes ☐ No

☐ Mobile / Work Phone Leave voice message: ☐ Yes ☐ No

☐ E-mail Address: ______________________________

Patient's Signature: ______________________ Date: ______________________

FOR CFSO OFFICE USE ONLY

Received by: ____________ Date: ____________ Processed by: ____________ Date: ____________

Result: ❐ Eligible ❐ Ineligible ❐ Immediate Assignment ❐ Inquiry Only ❐ Patient Declined Service ❐ Patient Unreachable
❐ Other: ______________________________

A United Way member agency