Mount Sinai Hospital
Sinai Health System
Joseph & Wolf Lebovic Health Complex

REFERRAL FORM
Couples and Family Therapy

Mount Sinai Hospital, Department of Psychiatry
600 University Avenue – 9TH floor, Toronto, ON M5G 1X5

Please PRINT CLEARLY and FAX to 416-586-8654 or put in 9th floor mailroom mailbox - Attn: Dr. Kalam Sutandar

PATIENTS MUST CALL IN TO EXPRESS INTEREST IN ORDER TO 'ACTIVATE' THE REFERRAL.
PLEASE ASK PATIENT TO CALL Couples & Family Therapy Program Assistant: 416-586-4800 x 8714

Referral Date: _____

Patient's Name: _____ DOB: _____

Address, City, Postal Code:
_____

MRN# (Mt. Sinai patients): _____ Health Card No: _____ Version Code: _____

Preferred Phone # with voicemail: (____)_____

Reason for referral and relevant history:

Referred by: _____ (___ _)_____
(Please print clearly) (Phone no.)

_____
(Address)

Referring MD/NP (signature): _____ OHIP Billing No: _____

REMINDER: We will NOT contact the family to offer an appointment until they have called (see above)

For internal use only

Date patient phoned in:
Date patient contacted w info re clinic:

Agreeable to being observed: yes/no Agreeable to receive therapy from resident: yes/no

1st contact with patient to offer appointment: No response from patient ☐
2nd contact with patient to offer appointment: No response from patient ☐

Assessment date: _____ Therapist: _____

Referral form updated Aug 3, 2018