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: CONNIE KIM

PATIENTS MUST CALL CLINIC WITHIN 6 MONTHS 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 contacted patient to provide info re nature of teaching clinic:

Safety concerns: yes/no
Substance use concerns: yes/no
Agreeable to observation for teaching: 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: _____
☐ Patient declined to pursue couples/family therapy
☐ Referral inactive - patient did not call within 6 months of referral or did not respond to 2 appointment offers

Referral form updated Dec 21, 2018