Capital Health

Centre for Emotions & Health

Referral for Consultation

Tel.: (902) 473-7172
Fax: (902) 473-1422

Name: _____ Gender: F ☐ M ☐ D.O.B. (yyyy/mm/dd): _____

HCN: _____ Expiry: (yyyy/mm/dd) _____

Address: _____

Telephone: (h) _____ (w) _____ Can a message be left: Yes ☐ No ☐

Presenting Symptoms: GI ☐ Resp ☐ CV ☐ MSK ☐ Neuro ☐ Anxiety ☐ Depression ☐

Other: _____

Confirmed Medical Problems: _____

_____

_____

Present Medications: _____

_____

_____

Requested Services: Psychodiagnostic Assessment ☐ Assess & Treat ☐

Other _____ Is patient aware of this referral? Yes ☐ No ☐

(Please attach reports of recent medical/surgical or mental health consultants.)

Referred by: _____ Tel: _____ Fax: _____

Agency: _____ Address: _____

Family Doctor: _____ Tel: _____ Fax: _____

REFERRAL DATE: _____