Community Family Services of Ontario 家和

416-979-8299
416-979-2743
info@CFSO.care
CFSO_TO
CFSO_4169798299
www.CFSO.care

SERVICE PROVIDER REFERRAL REQUEST FORM

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

Referrer's Name: _____ Agency / Organization: _____

Tel: _____ 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 #: _____ Cell/Work #: _____ E-mail: _____

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

Reason for Referral: ☐ Depression (Mild/Moderate) ☐ Anxiety (General/Social/Phobia) ☐ PTSD ☐ OCD

☐ Other: _____ Active Prescription(s): _____

NOTE TO REFERRER

Fax or e-mail completed referral form to 416-979-2743 or info@cfso.care for counselling at Community Family Services of Ontario. For psychotherapy, only patients with **common, mild-to-moderate mental health issues, who are following all required clinical 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 **Community Family Services of Ontario** (CFSO) to contact me by phone or email. If Community Family Services of Ontario is unable to reach me after 3 attempts within 1 month, this form would be destroyed and I would need to contact the CFSO myself if I require services from them.

I would like the Community Family Services of Ontario (CFSO) to contact me by (select all that apply):

☐ 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: _____