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 Client provided verbal consent to this referral ▢ Yes ▢ No

Fax completed referral form to 416-979-2743 or email info@cfso.care for Counselling at CFSO. For psychotherapy, only clients 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, _____ voluntarily consent & authorize **Community Family Services of Ontario** (CFSO) to contact me by phone or email. If CFSO 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.

I consent ▢ in writing / ▢ verbally for 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: _____