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 ☐ Self ☐ Other (specify): _____

Referrer's Name:_____Agency / Organization: _____

Tel: _____ Fax: _____ E-mail: _____

Reason(s) for Referral: ☐ Depression ■ Anxiety ☐ Trauma ☐ Domestic Violence ☐ Marital ☐ Parenting ☐ Children's Mental Health ☐ Problem Gambling ☐ Problem Gaming ☐ ASD ☐ ADHD ☐ Speech-Language ☐ Others

Details:_____

PATIENT'S INFORMATION: Is patient aware of this referral? ☐ Yes ☐ No Active Prescription(s): _____

Last Name: _____ First Name: _____

Date of Birth (YYYY/MM/DD):_____ Gender: ☐ Male ☐ Female ☐ Others:_____

Home #: _____ Cell/Work #: _____E-mail: _____

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

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 psychotherapy, only clients with **common, mild-to-moderate mental health issues and following all required clinical management** may 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: _____