VERIDIAN WELLNESS CLINICS
General Psychiatry Referral Form

PATIENT INFORMATION

First Name: _____

Last Name: _____

Date of Birth (mm/dd/yyyy): _____

Personal Health Number (PHN): _____

Province of PHN (Quebec PHN note accepted): _____

Sex: _____

Phone number: _____

Address (Street address, city, province, postal code):

_____

Email (Mandatory): _____

REFERRING PHYSICIAN INFORMATION

Name of referring physician: _____

BC MSP#: _____

Phone number: _____

Fax number: _____

Address: _____

Referrals with insufficient information will be sent back for correction

REASON FOR REFERRAL (One reason for referral only. Referrals with more than one reason will not be accepted and will be returned for clarification and re-submission):

☐ Depression

☐ Anxiety

☐ Other (please specify): _____

Please note we do not accept referrals with the following areas of complaints: child & adolescents aged 19 and under) issues, patients with major cognitive impairments, patients with psychosis, patients with complex care needs requiring social work, primary eating disorders, patients with primary complaints in the areas of neurodevelopmental disorder such as autism or learning disabilities (except ADHD), sexual medicine, history of significant head trauma, MCFD involvements, patients with on-going legal litigations/involvements, patients of no-fixed address, patients with primary personal disorders, patients with history of physical and verbal violence & aggressions. We also don't accept referrals for the purpose of needing psychiatric report for certain purposes (ex. Report for employment, licenses, claims, etc).

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Narrative description of reason for referral (legibly handwritten or separately attached type notes OK):

PLEASE CHECK THE FOLLOWING TO ACKNOLWEDGE:

☐ The referring physician agrees to remain as MRP

☐ The patient has been informed that any cost for services not covered by BC MSP/Provincial Health Insurances is the responsibility of the patient

☐ The patient has been informed of missed appointment fee policy of the Veridian Wellness Clinics (refer to https://www.veridianwellnessclinics.com/), and aware that the rate of the missed appointment fees are subject to change without notice

☐ referring physician/NP agrees not to make referrals with the following elements: child & adolescents aged 19 and under), patients with major cognitive impairments, patients with psychosis, patients with complex care needs, patients with primary complaints in the areas of neurodevelopmental disorder such as autism or learning disabilities (except ADHD), sexual medicine, history of significant head trauma, MCFD involvements, patients with on-going legal litigations/involvements, patients of no-fixed address, patients with primary personal disorders, patients with history of physical and verbal violence & aggressions

Referring physician signature: _____

Date of Referral: _____

Please fax all consultation request to the attention of:

Veridian Wellness Clinics

Fax: 6042275471