SUDHA PSYCHOTHERAPY

REFERRAL FORM

CLIENT INFORMATION	
Legal Name (First, Last):	**Preferred Name:**
Date Of Birth (DD/MM/YY): **Age:**	**Gender:** ☐ Female ☐ Male ☐ Trans Woman ☐ Trans Man ☐ Two-Spirit ☐ Genderqueer ☐ Gender fluid ☐ Androgynous ☐ Non-binary ☐ Other:
Language (Spoken/Preferred):	**Contact Information** (Phone number, Address): Phone Number: Address:
REFERRING PROVIDER INFORMATION	
Referring Provider Name (First, Last):	**Please select one of the following:** ☐ **Family Physician** ☐ **Psychiatrist** ☐ **Nurse Practitioner** ☐ **Other: _____**
Referring Provider Address:_____ **_____** **City: _____Province: _____** **Postal Code: _____ _____ Unit #: _____** **Telphone: Email:**	**Does your patient currently have a psychiatrist?** ☐ **Yes** ☐ **No** ☐ **Unknown** **If yes, please indicate the name of the psychiatrist,** **Name** (First, Last): **:_____** **Telephone: Email:**

1. REASON FOR REFERRAL	
Please indicate the primary reason for referral (specify current symptoms, presenting problems and history):	**Please select the service you're seeking for your patient:** ☐ Trauma informed(EMDR,IFS,EFT) ☐ Specific Treatment (e.g. Emotionally Focussed,CBT,Mindfulness,Somatic): ☐ Other
2. RISKS AND SAFETY CONCERNS(self harm, suicide attempts, legal involvement,substance use)	
3. MEDICATION (both psychiatric and non-psychiatric medication)	
4. RELEVANT MEDICAL/ DEVELOPMENTAL HISTORY (e.g. disabilities, intellectual delay, autism, allergies, endocrine, neurological, respiratory, cardiac, metabolic or other issues)	
5. Would you like updates after the patient has been in therapy?	
☐ **Yes** ☐ **No**	If yes-how frequent would you like updates? ☐ 3 months ☐ 6 months ☐ 1 year

After completing the form-kindly upload to the website(www.sudhapsychotherapy.com) under Referrals tab and click 'Upload Form'

THANK YOU !