MindSeed Health – Referral Form

Please complete this form and fax to 416-223-5913 or email to info@mindseedhealth.com.

Date of Referral: ___________ (mm/dd/yyyy)

Patient Information

Full Name		Date of Birth	___________ (mm/dd/yyyy)
Phone		Email	
Can we leave a voicemail at this number? ☐ Yes ☐ No ☐ Unsure			
Street Address		City	
Province		Postal Code	

Referring Provider Information

Full Name		Fax	
Phone		Email	
Relationship to patient			
Are you the Most Responsible Physician (MRP)? ☐ Yes ☐ No			
If No to the above, please provide the full name and phone number for the patient's MRP/ or family physician:			

Clinical Information

Urgency: ☐ Urgent ☐ Non-Urgent
Reason for referral / Problems leading to referral:
Main Dx:
Desired outcome goals:
Suicidality – Current: ☐ Yes ☐ No ☐ Unknown Suicidality – Past: ☐ Yes ☐ No ☐ Unknown If Yes to either of the above, please provide details:
History of violence*: ☐ Yes ☐ No ☐ Unknown *_Please note that we do not accept forensic cases._ If Yes to the above, please provide details:
History of substances – Current: ☐ Yes ☐ No ☐ Unknown History of substances – Past: ☐ Yes ☐ No ☐ Unknown If Yes to either of the above, please provide details:
Please indicate if there is known trauma history, and provide details: