

# Arnika Centre

## Referral Form

### PATIENT

Name: \_\_\_\_\_

DOB: ( DD MM YYYY ) \_\_\_\_\_ Sex:  M  F

AHCIP#: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone (r):( ) \_\_\_\_\_ (b):( ) \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone:( ) \_\_\_\_\_

Street Address: \_\_\_\_\_

Guardian: \_\_\_\_\_ Phone:( ) \_\_\_\_\_

Agencies Involved: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone:( ) \_\_\_\_\_

Indicate level of intellectual disability:  mild  moderate  severe  profound  unknown

Presenting concern: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Past medical history: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medication(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is this individual currently receiving psychiatric service?  no  yes

If yes, provide name of psychiatrist: \_\_\_\_\_

Date of last visit: \_\_\_\_\_

Has this individual been seen at Arnika Centre in the past?  no  yes

If yes, provide name of psychiatrist: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Physician request:  Dr. S. Carpenter  Dr. D. Dawson  Dr. L. Hogg  Dr. K.Tanguay  
 Dr. J. Cohen  any physician

Referring physician: \_\_\_\_\_ Pracid number: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

