Please fax completed referral to 416-764-5507 or
send through TELUS MedDialog to Dr. Tim Guimond at 200344305@200344303

HQ Addiction Medicine Referral Form

You can use your standard template for referral letter if it has the below information.

Patient Information (or sticker with same):

Last Name: _____ **First:** _____

D.O.B. dd/mm/yyyy Age: _____

Address: _____

City: _____ **Prov:** _____Postal: _____

OHIP #:_____VC:_____

OHIP Sex designation: _____ Gender: _____

Preferred Name: _____ Pronouns: _____

Contact #: _____

*E-mail: _____

Referring Contact Information (or stamp)

Name:

Role: ☐ Family Physician ☐ Psychiatrist
☐ Nurse Practitioner ☐ Social worker
☐ Therapist ☐ Other:

Billing Number:

Address:

Telephone:

Fax:

Email:

Our clinic serves gay, bisexual and other men who have sex with men, and all trans, non-binary and 2 spirit community members. Please confirm your patient is a member of one of these communities. ☐ Confirmed

* We use email to contact patients to complete our initial self-assessment, please include email above.

Consent to Contact Patient

Please obtain consent from your patient regarding the use of phone/voicemail, text messages and email communication for the purposes of contacting them regarding this referral, arranging appointments and the use of eForms (online self - assessment forms through secure portal). Voicemail/Email Yes ☐ No ☐ Text messages Yes ☐ No ☐

Interpreter: ☐

Other Accessibility Concerns:

Reason for Referral

Select primary need:

Addiction Medicine ☐

~~Psychiatric Consultation~~ ■

Psychiatric consultation is not currently available (please monitor our website to determine when this service resumes).

Psychotherapy Groups ☐

Name of group (if known)

Comments:

Optional

Please consider adding any additional information that may be helpful in completing the most useful consultation for you and your team. This can be attached or commented on here. This may include:

1. Specific symptoms or problems of concern
2. Previous psychiatric consultation reports
3. Previous and/or ongoing treatment (psychotherapy, medication)
    a. For medications, consider past and current trials, max dose/duration, and any adverse events.
4. Current substance use
5. Specific safety concerns such as those related to risk of suicide, self-harm or harm towards others. Please note that this information is not used to exclude access but rather to support our team in preparing to best assist.
6. Relevant past medical history

Completed by: Signature: Date (dd/mm/yyyy):

For any questions regarding the referral process, please email us at mh@hqtoronto.ca