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

HQ Mental Health Referral Form for Physicians/Nurse Practitioners

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
☐ Other physician:

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 (our clinic uses text messaging to communicate with patients)

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). Phone/Voicemail/Email ☐ Yes ☐ No ; Text messages ☐ Yes ☐ No

Interpreter:

Other Accessibility Concerns:

Reason for Referral:

Select primary need:

Addiction Medicine ☐ Psychiatric Consultation ☐ Psychotherapy Groups* ☐ Name group:

This option (*) is intended for referral to a specific modality based on a psychiatric/addictions medicine recommendation (please attach consult note describing needed modality), otherwise patients can come to clinic to self-refer and we will assess for the most appropriate groups.

Other question/comments:

Optional

Please consider adding any additional information that may be helpful in completing the most useful consultation for you and your team. 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 (not an exclusion)
5. Specific safety concerns such as those related to risk of suicide, self-harm or harm towards others. (not an exclusion)
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

For non-physician referrals, please see our website: https://hqtoronto.ca/mhreferral/