Please print the completed form and ask the patient bring this to HQ at 790 Bay Street, Suite 820, to register for mental health care (instructions can be found on the page 2). * ***Patients who are ALREADY receiving care at HQ can optionally be referred by fax at 416-764-5507 and we will email them a mental health intake questionnaire;*** if the patient does not receive an invitation for an email to complete the intake questionnaires within 4 days, they should come to HQ to confirm their contact information.
Faxed referrals of patients not previously receiving care at HQ will not be acted upon until the patient has registered in person so that they can provided consent to be contacted by electronic means.

HQ Toronto

HQ Mental Health Referral Form for Non-Physicians/Non-Nurse Practitioners

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:
Agency:
Role: ☐ Case Worker ☐ Therapist
☐ Psychologist
☐ Other role:
Address:
Telephone:
Fax:
Email:
☐ Our agency will continue to be involved

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

Information for your patient about our services:

Our mental health services are offered almost exclusively in groups and always include group involvement, patients not interested in group will not likely benefit from a referral. Please also let the patient know that our clinic routinely uses text messages and email communication for the purposes of contacting them for reminders for group therapy, arranging appointments and the use of eForms (online self-assessment forms through a secure portal).

Accessibility Concerns:

Reason for Referral:

Select primary need:

Substance use ☐ Mental health ☐ Concurrent disorder ☐ A specific group, name group:
Other information:

Optional

Please consider adding any additional information that may be helpful in completing the most useful care for this patient. 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 physician referrals, please see our website: https://hqtoronto.ca/mhreferral/