401-1100 Sheppard Ave. East
Toronto, ON M2K 2W1

Kamran Bordbar, MD, FRCP(C)
Referral Form

T: (416) 548-9701
F: (416) 548-9702

Referring Source			**Date:** dd / mm / yyyy
Name	Title/Position/GP/Specialist	Phone (___) ___ - ____	Fax (___) ___ - ____
Address			
City	Province	Postal Code	Billing No: ______

Patient Information				
First Name	Middle Name	Last Name		
Date of Birth dd / mm / yyyy	Age		☐ Male	☐ Female
OHIP Card Information:	Number ____ - ____ - ____ - ___		Expiry dd / mm / yyyy	
Contact Information	Home (___) ___ - ____	Work (___) ___ - ____	Cell (___) ___ - ____	
Address				
City	Province	Postal Code		
Emergency Contact:	Name	Relationship	Phone (___) ___ - ____	

Reason for Referral	☐ Patient was last assessed on: dd / mm / yyyy		☐ Patient could not be assessed	
Whose idea was it to arrange this referral?	☐ Doctor	☐ Patient	☐ Family	☐ Other
Please explain				
What is the main purpose of this referral?	☐ Diagnosis	☐ Treatment	☐ 2nd opinion	☐ Other
Please explain				
What are the main concerns/problems at this time?				
Please explain				

Current Medications	**Previous Medications**
Medical Conditions	**Investigations**
Current Psychiatric Diagnoses	**Previous Psychiatric Diagnoses**

Employment Status			
☐ Employed	☐ Self-employed	☐ Disability	☐ Retired
☐ Unemployed	☐ Employment Insurance	☐ WSIB	☐ Social Assistance
☐ Student	☐ Full Time	☐ Part Time	☐ Homemaker

Condition Related to			
☐ Employment	☐ Injuries (Work or Auto)	☐ Insurance	☐ School
☐ Violence or Aggression	☐ Self-harm or Suicidality	☐ Drugs/Alcohol	☐ Legal Procedures
☐ Family/Partner	☐ Friends/Relatives	☐ Relationships	☐ Abuse
Please explain			

Other Contacts				
Family Physician	Name	Phone (___) ___ - ____	Fax (___) ___ - ____	
Other Physician	Name	Phone (___) ___ - ____	Fax (___) ___ - ____	
Psychiatrist	Name	Phone (___) ___ - ____	Fax (___) ___ - ____	
Psychologist	Name	Phone (___) ___ - ____	Fax (___) ___ - ____	
Therapist/Counsellor	Name	Phone (___) ___ - ____	Fax (___) ___ - ____	
Other	Name	Phone (___) ___ - ____	Fax (___) ___ - ____	
Additional Documents	☐ Cumulative Patient Profile	☐ Consultations / Assessments	☐ Not Attached	☐ Not available