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