Health Sciences North/Horizon Santé Nord

Northeastern Ontario Structured Psychotherapy Program
Health Sciences North
Programme Psychothérapie structurée Ontario – Nord-Est
Horizon Santé-Nord

*For office use only** SH:____________________Date Received: ________________
Date of screening:______________Start time:_________End Time: _______________

Date of Referral *(DD/MM/YYYY):*______

Ontario Structured Psychotherapy (OSP) Referral Form

(Services for Depression, Anxiety and Anxiety-Related Conditions)

Client/Patient Information

Legal Name *(Last name, First name):*

____

Preferred Name *(If Applicable):*

____

Date Of Birth *(DD/MM/YYYY):*________________**Age**: _____

Health Card Number:____________________**VC:** ______

Expiry date *(DD/MM/YYYY):* ______________________

Address: ____________________________________

City:____

Postal Code:_____________________

Telephone number(s)

Home:______________________

Cell: _______________________

Please confirm if confidential messages can be left?

❒ Yes ❒ No

Email address *(If any):* __________________________

Can we send correspondence to this email address?

❒ Yes ❒ No

What is your mother tongue?

❒ English ❒ French ❒ Other:______________________

If your mother tongue is neither French nor English, in which of Canada's official languages are you most comfortable?

❒ English ❒ French

Is there a need for an interpreter?

❒ Yes ❒ No *(If yes, specify details)*:

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Do you have accessibility needs? ❒ Yes ❒ No

If yes, specify____________________________________

Is there an alternative contact? ❒ Yes ❒ No

Name:____

Relationship to client/patient: ____________________

Telephone number:______________________________

What is your gender identity? _____________________

Your Pronouns:___________________________________

What is your Ethnicity: __________________________

What are the best days/times to contact you?

____

Referral information

Do you have a primary care provider (doctor or nurse practitioner)? ❒ **Yes** ❒ **No**

If yes, Name: _______

Address:____

Telephone Number: ______________________________

Who is making the referral:
__Self __Care Provider Name:

If care provider different from above provide:
Name: Phone Number:

Please check any of the following experiences that apply to you:

Suicidal attempts in the past 6 months	❒ Yes ❒ No
Thoughts of hurting yourself or anyone else	❒ Yes ❒ No
Very elevated or irritated mood with impulsive behaviour that causes problems in your life	❒ Yes ❒ No
Seeing or hearing things others do not or having ideas that others find very hard to understand or unusual	❒ Yes ❒ No
Symptoms of an eating disorder that cause you a lot of distress	❒ Yes ❒ No
Self-harm	❒ Yes ❒ No
Problems with substance use that impact your work, family, or social life	❒ Yes ❒ No
Have you been diagnosed with a personality disorder	❒ Yes ❒ No

Which of the following best describes what you are most wanting help with?

❒ Depressed mood ❒ Specific fears
❒ Social anxiety ❒ Excessive worry
❒ Panic attacks ❒ General life stress
❒ Obsessive compulsive concerns
❒ Post-traumatic stress ❒ Health anxiety
❒ Other: __________________________

Main reason for seeking services: ____________________

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Return by Fax-705-669-1594 or by Mail: OSP program, 8th floor 127 Cedar Street, Sudbury, ON, P3E 1A9