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

(Non-Urgent/Non-Crisis 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)*:

_____

_____

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: _____

_____

_____

_____

_____

Return completed form to our unmonitored fax-705-669-1594 or by mail: OSP program, 8th floor 127 Cedar Street, Sudbury, ON, P3E 1A9