

**Referral for Sports Psychiatry Consultation** **Date:**

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| **Patient Information:**  Name: Parents names (if patient <16):  Address:  D..O.B.:  OHIP:  Tel:  Alt. Tel:  E-mail (if available): | |  |
| **Reason for referral:** |  | |
| **Psychiatric History:** |  | |
| **Medical History:** |  | |
| **Medications: (past, present)** |  | |
| **Allergies:** |  | |
| **Safety Concerns (including self harm, aggression):** |  | |
| **Referring Physician:**  Name:  Tel:  Fax:  OHIP Billing Number: | **Physician Signature:** | |

**Please fax form to 519-763-9096**

Dr. Carla Edwards

Synergy Sport + Mental Health

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