# REFERRAL REQUISITION

This Requisition form, when completed, constitutes a referral to IMPRESSIONS FCS Inc. It is for the use of authorized health care providers only.

THIS AREA IS FOR OFFICE USE

***COMPLETE and ACCURATE information is required in all shaded areas.***

| Patient Surname | First | Initial(s) | Date of Birth (DAY / MONTH / YEAR) | Sex |
|---|---|---|---|---|
| | | | | ☐ F ☐ M |

| Patient Address | City, Province | Postal Code | Patient Telephone Number (HOME / CELL) | ☐ Y ☐ N Contact? |
|---|---|---|---|---|
| | | | | |

| Ordering Physician, Address, MSP Practitioner Number | Locum for: | Referral Status: | Service Type: |
|---|---|---|---|
| | Physician _____ | ☐ Urgent | ☐ In-office services *(Currently unavailable)* |
| | MSC# _____ | ☐ Normal | ☒ On-line services |

| Presenting Problem(s): | Diagnosis, if any: |
|---|---|
| | |

| | | | Date of Referral (YEAR / MONTH / DAY) |
|---|---|---|---|
| Does patient present any risk of self-harm or suicidal ideation? | ☐ Yes | ☐ No | |
| Does patient present any homicidal tendancies? | ☐ Yes | ☐ No | |
| Is patient known for violence or disruptive behaviours? | ☐ Yes | ☐ No | |

**Does referring Physician wish to receive Patient progress reports?**

☐ Yes ☐ No

***If YES, please complete the *Consent to Release Medical Information* Authorization form below.**

## CONSENT TO RELEASE MEDICAL INFORMATION

***Pursuant to the Personal Health Information Protection Act, 2004***

The patient, *as identified on this physician referral form,* hereby authorizes the referring physician to submit this active referral for mental health services to **IMPRESSIONS Family Counselling Services Inc.** for the purposes listed above and to release/disclose and/or receive/accept personal and private information pertaining to the patient's health and well-being, in addition to clinical notes, assessment records and results, diagnosis and treatment plans, consultation reports, progress reports and other pertinent health information required in the on-going care of the patient.

## ACKNOWLEDGMENT AND CONSENT STATEMENT

The patient, *as identified on this physician referral form* , consents and authorizes **IMPRESSIONS Family Counselling Services Inc.** who has records, knowledge or information regarding my health/medical conditions to release and/or receive such health/medical records/information to the referring physician identified on this referral form, for the purposes stated above.

The patient understands why they have been asked to authorize the disclosure of this information and is aware of the risks and benefits of consenting, or refusing to consent, to the disclosure.

**EFFECTIVE DATE:** This consent will be valid for 6 months from this date.

| YEAR | MONTH | DAY |
|---|---|---|
| | | |

☒ _____

**Signature of patient**, or representative, if patient is incapable of signing or making a personal decision.

**Representative:** If signed by representative, describe the relationship or authority (for example: parent, spouse, legal guardian, personal directive, power of attorney, etc.)

**Name of person signing above (please print)**

**Name of Representative signing above (please print)**

**Referring physician stamp**

☒ _____

**Referring physician signature**

**RETURN TO:** **IMPRESSIONS Family Counselling Services Inc.**
P.O. Box 27002, Victoria, BC V9B 5S4
**Phone:** (778) 557-8478
**E-Mail:** admin@impressions-counselling.org
**WEB:** www.impressions-counselling.org



**REFERRALS CAN BE FAXED TO**

# (778) 557-8558

**OR PROVIDED TO PATIENT FOR SUBMISSION**