Homewood Health

Interventional Psychiatry Services Referral Form

Reset Form

Date of Referral _____

Information for Referring Providers

- A Physician or Nurse Practitioner referral is required (self-referral is not accepted)
- It is preferred that the referral comes from the treating psychiatrist.
- For Electroconvulsive Therapy (ECT) the patient must have a treating psychiatrist and the referral is required to be completed by them.
- The referring physician must continue to provide care after the patient has completed time-limited treatments offered within the Interventional Psychiatry Program.

Has the patient received any of these treatments before?	**Yes**	**Complications**
Repetitive Transcranial Magnetic Stimulation	☐	
Electroconvulsive Therapy	☐	
IV / Intranasal Ketamine Treatment	☐	
Other (please specify)	☐	

Referring Clinician Information

Your Name: _____ Phone Number _____ Ext: _____

Your Health Care Discipline (e.g. Family Medicine, Psychiatry): _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Country: Canada Email: _____

Telephone: _____ Fax: _____

OHIP Billing # (referred by an Ontario Physician or Nurse Practitioner): _____

Are you referring as part of: WSIB ☐ Dept. of National Defense ☐ Veterans Affairs ☐ Other: ☐

Please send Referral Form, Medication List and copies of past records and most recent lab reports to:
Interventional Psychiatry Services, Homewood Health Centre
Ph: 519-824-1010 x 32164 | Fax: 519-838-1118 | Email: InterventionalPsychiatryService@homewoodhealth.com

Homewood Health

Patient Information:

Patient Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Country: _____ Email Address: _____

Telephone: _____ Business/Mobile Phone: _____

Date of Birth (YY-MM-DD): _____ Health Card#: _____ Version Code: _____

Department of National Defence Blue Cross Service # : _____ Veterans Affairs K# _____

Please select service this referral is indicated for:

- ☐ Repetitive Transcranial Magnetic Stimulation
- ☐ Electroconvulsive Therapy *psychiatrist referral required for ETC*
- ☐ IV Ketamine
- ☐ Esketamine

Primary reason for referral:

Medical History (please include relevant reports):

Allergies:

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