Pathstone Mental Health

Primary Care Referral Form

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Patient's Personal Information

Name:	Pref. Name:		**Health Card Number & VC:**	
Address :	City :		Postal Code	
Telephone :	Cell :		Other :	
DOB :	Age :		Gender :	
Parent's Name :		Parent's Name :		
Resides with : (Choose)		Custody Type: N/A	Joint	Sole
Family Physician :		Telephone : - -		
		Telephone : - -		

Referral Information

Referred by :	Date :	**Physician's Billing # :**

Reason for Referral (Required):

Medication **List of Current Medications-Please print clearly**

Name of Medication	Dosage	Frequency
Allergies		

Consent and Agreement

I/, WE THE UNDERSIGNED AGREE TO THE EXCHANGE OF PERSONAL HEALTH INFORMATION BETWEEN AND PATHSTONE MENTAL HEALTH. I FURTHER AGREE TO THE PERSONAL HEALTH INFORMATION EXCHANGE BETWEEN PATHSONE MENTAL HEALTH AND NIAGARA HEALTH BE COLLECTED, USED, OR DISCLOSED FOR THE PURPOSE OF REFERRAL, TREATMENT PLANNING, COORDINATION AND FOLLOW UP SERVICES/SUPPORTS. I ALSO AGREE TO A SOCIAL WORKER CALLING ME FOR THE PURPOSE OF COMPLETING AN INTAKE.

SIGNATURE _____ DATE _____