



PATIENT REFERRAL REQUISITION - PHYSICIAN

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			Sex	
					DAY	MONTH	YEAR	<input type="checkbox"/> F	<input type="checkbox"/> M
Patient Address			City, Province		Postal Code		Patient Telephone Number		
							HOME	CELL	<input type="checkbox"/> Y <input type="checkbox"/> N Contact?
Ordering Physician, Address, MSP Practitioner Number			Locum for:		Referral Status:		Service Type:		
			Physician _____		<input type="checkbox"/> Urgent		<input type="checkbox"/> In-office services (*Currently unavailable)		
			MSC# _____		<input type="checkbox"/> Normal		<input checked="" type="checkbox"/> On-line services/phone		

Presenting Problem(s):	Diagnosis, if any:

Does patient present any risk of self-harm or suicidal ideation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Referral
Does patient present any homicidal tendencies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Is patient known for violence or disruptive behaviours?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Does referring Physician wish to receive Patient progress reports?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	YEAR MONTH DAY
			*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/discard 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
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Signature of patient, or representative, if patient is incapable of signing or making a personal decision.

Name of person signing above (please print)

Referring physician stamp

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

Name of Representative signing above (please print)



Referring physician signature

RETURN TO: IMPRESSIONS Family Counselling Services Inc.
P.O. Box 3244, INUVIK, NT X0E 0T08
Phone: (866) 708-3501
E-Mail: admin@impressions-counselling.org
WEB: www.impressions-counselling.org

REFERRALS CAN BE FAXED TO
(866) 708-3501