Psychedelic Assisted Therapy (Oral) – Referral Form (Hamilton Location)

PAIN CARE CLINICS

Hamilton Clinic: 1223 Barton Street E Unit S5, Hamilton ON L8H 2V4

Patient Information

Patient Name:
DOB:
Email:
Phone Number:
Alternate Phone Number:

Referral Criteria

- ☐ Agreeable to self-pay 2K +HST, and for medications
- ☐ Patient has a confirmed diagnosis of Anxiety, Depression or PTSD and is currently receiving or open to receiving psychotherapy
- ☐ Agreeable to in clinic (Hamilton) and remote appointments
- ☐ Has been treated with conventional therapies in the past: medications, group CBT, psychotherapy, ECT which have proven not to be effective
- ☐ Patient is over 18 and is not nursing, pregnant / nor has plans to become pregnant in the next 3 months
- ☐ Patient does not have a personal or family history of psychosis
- ☐ Patient is not actively suicidal
- ☐ Patient is not currently misusing substances (alcohol, cannabis, prescription or non-prescription drugs)
- ☐ Patient does not have a seizure disorder
- ☐ Patient does not have an unstable cardiac disease

Medical Provider Info

CPSO #	Billing #
Dr./NP:	Phone Number:
Fax Number:	Address:
City & Province:	Postal Code:

Are you the patient's Family Physician or Most Responsible Physician (MRP): ☐ Yes ☐ No

Reason For Referral

Provider Signature:

Please complete and fax in this form

FAX: 1-888-533-6512 | PHONE: 1-844-622-7246