Anxiety Treatment and Research Centre

St. Joseph's Healthcare Hamilton
301 James St. S., 6th Floor, Fontbonne Bldg.
Hamilton, ON, L8N 4A6
Phone: (905) 522-1155 ext. 33697
Fax: (905) 521-6120
Website: www.stjoes.ca/anxiety

Randi E. McCabe, Ph.D. (Director)
Richard P. Swinson, M.D. (Medical Director)
Martin M. Antony, Ph.D. (Research Director)

- The Anxiety Treatment and Research Centre (ATRC) offers comprehensive assessment and treatment for people whose ***principal*** problems are due to anxiety. We are **not** able to serve people who have primary difficulties with depression and mood disorders, substance use disorders, psychotic disorders, and other problems such as eating disorders.
- Our treatment programs are focused primarily on Obsessive Compulsive Disorder, Social Phobia and Panic Disorder. Limited resources are available for Specific Phobias and Generalized Anxiety Disorder.
- The Anxiety Treatment and Research Centre offers consultation to referring physicians and time-limited treatment when appropriate. In cases where we cannot provide treatment, additional referral options will be provided to the referring physician
- In cases where we are unable to assess a referred patient, the referring physician will be contacted.
- If you are unsure as to the suitability of a referral to the ATRC please call Judy Odom at 905 522 1155 x33697

Referral Form

To refer a patient to the program please complete and return this form by mail or fax. We will contact the patient directly for additional screening by telephone or when an assessment appointment becomes available.

Date of Referral: _______/_____/_____
dd / mm / yy

Referring Physician / Agency: ____

Address: ____

____

Tel: (____) ____________________ Fax: (____) ____________________

Physician's Billing Number ____________________ Signature ____________________

Patient Last Name: ____________________ **First Name:** ____________________ **Initial:** _____

Address (number & street): ____

City: ____________________ **Postal Code:** _____ _____ **OHIP Number:** ________________

Tel: Home (_____) ____________________ **Work** (_____) ____________________

Date of Birth: d_____m_____y_____ **Gender:** Male ( ) Female ( ) **Age:** ________

Marital status: __________________ Is patient employed?: ( ) Yes ( ) No ( ) Don't know

If employed, occupation of patient ________________________

www.stjoes.ca/anxiety

Purpose of Referral (check all that apply):

( ) Opinion regarding diagnosis and treatment
( ) Medication consultation
( ) Cognitive Behaviour Therapy
( ) Other: ____________________________

Prominent symptoms (check all that apply):

( ) Panic attacks
( ) Obsessions or compulsions
( ) Social anxiety or shyness
( ) Persistent worrying
( ) Distress after a traumatic event
( ) Specific fears (i.e., specific phobia)
( ) Other ________________________

Which of these is the most disabling problem currently? ______________________________

Please check all items that apply to this patient:

( ) Current substance abuse
( ) Hallucinations or delusions (past or present)
( ) Suicide attempt (when? ________________)
( ) Depression
( ) History of violence or legal problems
( ) Currently has suicidal ideation
( ) Personality disorder

Brief description of **presenting problem** (attach report if available): ______________________________

____

____

____

____

Relevant Medical History ____

____

____

Is this patient currently in treatment with a mental health professional?

( ) Yes ( ) No ( ) Don't know If yes, please name mental health professional: ______________

Current Medications ____

____

Has this patient been a psychiatric inpatient? ( ) Yes ( ) No ( ) Don't know

If yes, where and when?

Has this patient previously been a patient of St Josephs Healthcare Hamilton? ( )Yes ( ) No ( ) Don't know

Has this patient previously been seen at the ATRC? ( )Yes ( ) No ( ) Don't know

Thank you for completing this form and for referring your patient. We will be in contact with them as soon as possible