Anxiety Treatment and Research Clinic

St. Joseph's Healthcare Hamilton
100 West 5th Street, Hamilton, ON L8N 3K7
Phone: (905) 522-1155 ext. 33697
Fax: (905) 521-6120
Website: www.stjoes.ca/anxiety

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- The Anxiety Treatment and Research Clinic (ATRC) offers 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 include **group-based** cognitive behavioural therapy for a variety of anxiety disorders and consultation about medication treatments. We also offer social work and occupational therapy services.
- The Anxiety Treatment and Research Clinic 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:** _____ _____ **HIN Number:** _____

Tel: Home (_____) _____ **Work or Cell** (_____) _____

Date of Birth: d_____m_____y_____ **Gender:** Male ( ) Female ( ) Transgendered ( ) Intersex ( )

Age: _____ **Marital status:** _____ Is patient employed? ( ) Yes ( ) No ( ) Don't know

If employed, occupation of patient _____

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