



MENTAL HEALTH & FREEDOM

IFHP Physician Referral Form

Please complete this form with the patient's diagnosis and recommendation for psychotherapy/counselling to support IFHP-funded mental health services.

Patient's Full Name: _____ Patient's Phone Number: _____
Patient's Date of Birth: _____ Patient's Email Address: _____

Diagnosis:

The above-named patient presents with symptoms consistent with DSM-5 diagnostic criteria for:

- Adjustment Disorder
- Post-Traumatic Stress Disorder (PTSD)
- Generalized Anxiety Disorder
- Social Anxiety Disorder
- Panic Disorder
- Major Depressive Disorder Personality Disorder
- Attention Deficit/Hyperactivity Disorder (ADHD)
- Other (Please Specify) _____

_____ Referral for Mental Health Services Needed:

The above named patient requires counselling to address mental health concerns.

Referring Physician:

Physician's Full Name _____ Physician Registration Number: _____

_____ Physician's Signature

Date: _____

✉ Email: info@mentalhealthandfreedom.com

☎ Phone (416)832-7060

🌐 Website: mentalhealthandfreedom.com