OAK TREE THERAPY

Unit 209-2110 Main Street
Phone: (204) 336-2144
Winnipeg, Manitoba R2V 2C2
harmanjot.kaur@oaktreetherapy.ca

Unit 2-232 Henderson Hwy
Phone: (204) 336-2144
Winnipeg, MB, R2L 1L9
crystal.rogasky@oaktreetherapy.ca

REFERRAL FORM

Date of referral: _____

Type of referral: ☐ Psychotherapy sessions ☐ Psychological assessment

Referral Source (Agency/Person): _____

Date of service requested: _____

Location of service requested: _____

Client's Name: _____ Age: _____

Date of Birth (required): _____ **Treaty number** (if applicable): _____

Address (required): _____

Phone Number (required): _____ Email (required): _____

What is your current gender identity? (Check ALL that apply) ☐ Decline to answer ☐ Male ☐ Female

☐ Transgender Male/Transman/FTM ☐ Transgender Female/Transwoman/MTF ☐ Gender Queer

☐ Additional category (please specify): _____

Preferred Pronouns: (Check all that apply) ☐ She/her/hers ☐ He/him/his ☐ They/them/theirs

☐ Other (Please specify): _____

Parent/Legal Guardian(s) Information:

Father Info:

Name: _____

Contact Information if different from above:

Address: _____

Home No: _____

Cell No: _____

Email: _____

Mother Info:

Name: _____

Contact Information if different from above:

Address: _____

Home No: _____

Cell No: _____

Email: _____

Child lives with: (Check all that apply) ☐ Father ☐ Mother ☐ Both parents ☐ Other

(Please Specify): _____

Is CFS involved with the family? ☐ Yes ☐ No

Legal Status (i.e., PW, TO, VSG, VPA, Apprehension): _____

Agency (if applicable): _____

Agency Address: _____

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Social Worker Name: _____ Ph: _____

Email: _____

Supervisor Name: _____ Ph: _____

Email: _____

Foster Parent Name(s): _____ Ph: _____

Email: _____

CURRENT MENTAL HEALTH CONCERNS:

☐ Anxiety ☐ Depression ☐ Racing thoughts ☐ Paranoia ☐ Behavioral Challenges ☐ Eating disorder
☐ PTSD ☐ Addiction ☐ Trouble Concentrating ☐ Unstable Relationships ☐ Trauma
☐ Sudden Emotional Changes ☐ Other (Please specify): _____
Are you or the client experiencing suicidal thoughts: ☐ Yes ☐ No
Are you or the client engaging in self harm: ☐ Yes ☐ No
Has your client made previous suicide attempt(s): ☐ Yes ☐ No How many? _____
Aggressive Behaviour Towards: ☐ Self ☐ Other ☐ Property

SUBSTANCE USE HISTORY: ☐ Yes ☐ No ☐ Suspected
☐ Alcohol ☐ Cocaine ☐ Heroin ☐ Crystal Methamphetamine ☐ Marijuana ☐ Solvents/gasoline
☐ Ecstasy ☐ Fentanyl ☐ Misuse of other Prescription Drugs ☐ Illicit Methadone
☐ Misuse of over-the-Counter Medication ☐ Other: _____

TREATMENT HISTORY:
Current Medications: _____
Therapeutic strategies used in the past: (Cognitive- Behavioral Therapy, supportive counseling etc.)
Please Specify: _____
☐ No previous psychiatric diagnosis
☐ Current or previous psychiatric diagnosis (explain): _____
☐ Suspected diagnosis (explain): _____
Relevant developmental history: ☐ Autism ☐ ADHD ☐ FASD ☐ Other (Please Specify): _____
Intellectual delay/ Cognitive impairment: ☐ Yes ☐ No
Brain/ Head injury: ☐ Yes ☐ No
Previous psychological assessment: ☐ Yes ☐ No

LEGAL CHARGES/INVOLVEMENT:
☐ Yes ☐ No Please Describe: _____
_____

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LIVING SITUATION:

☐ Stable ☐ Unstable ☐ Alone ☐ With Family/Partner ☐ Foster Home

☐ Assisted Living ☐ Group Home ☐ Homeless Shelter

☐ Other: _____

FINANCIAL SITUATION

☐ Employed ☐ Unemployed ☐ Disability ☐ Employment and Income Assistance ☐ Self-Employed ☐ Student

OTHER PERTINENT INFORMATION (family history of mental health issues, family issue, other stressors)
Special Considerations: _____

Reasons for referral (Precipitating factors that led to service request (i.e., Trauma event, major incident):

_____
_____
_____
_____
_____
_____
_____
_____
_____

Funding Source:

☐ JP ☐NIHB ☐Agency Contract ☐ Private Pay ☐ Unknown

***** Please provide any pertinent records you have on file (Discharge summaries, FASD, CDC, psychological assessment) or consider requesting them with your client's consent. *****

***** A social history is not required, but is greatly appreciated at time of referral, or shortly thereafter*****