Dr. Shira Taylor MD, CCFP

Family Physician with Focused Practice in Medical Psychotherapy
Referral and Request for Consultation Form
New Patients: Please fax to 705-704-9277

Date: _____

Referring Clinician Information:

Name:	Billing #:
Phone:	Fax:
Family Physician (if different):	Family Physician fax:

Patient Information:

Name:	OHIP w/ VC:
DOB:	Fax:
Best email contact:	Best phone contact:

Step 1: I attest that this patient is medically and psychiatrically stable enough & available for group-based sessions requiring daily mind-body practices. _____ (clinician initials here)

Step 2: To which Group Service(s) are you referring this patient? (please check)
___ Minding Your Inner Monkey Online
___ Mindfulness Based Cognitive Therapy (MBCT)
___ Interpersonal Boundaries Weekend Workshop

Step 3: Please fax this form along with a summary of the patient's (4 items):
1) Past Medical History;
2) Psychiatric History;
3) Any available Psychiatric Consultation Notes; and,
4) Current Medication(s) & Dose(s).

Please direct patients to www.drshirataylor.ca for further details.

Clinician's Signature:

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