



OHIP REFERRAL FORM (MD/NP)

1. REASON FOR REFERRAL FOR CBT

- Depression/Anxiety Insomnia (CBT-i) Chronic Fatigue Chronic Headache
 Lower Back Pain Hypertension Post-concussion

2. PATIENT'S EMAIL ADDRESS

3. PATIENT'S DEMOGRAPHICS

(Or attach patient's demographics sticker)

	NO ACCESS BONUS NEGATION
	OHIP-FUNDED
	VIRTUAL SERVICES AVAILABLE ONTARIO-WIDE

Name _____

Date of birth (dd/mm/yy) _____

Address _____

City & Postal Code _____

Health Card Number _____

Phone Number _____

4. REFERRING MD/NP'S INFORMATION

MD/NP Name _____

MD/NP OHIP # _____

MD/NP Fax # _____

Date of Referral _____

ATTENTION FHO PHYSICIANS: Referral to us will not affect your access bonus.

Our physicians are specialists or have GP-Focused Practice Designations in Psychotherapy, allowing them to see patients without affecting your access bonus. To review the billing codes we use, visit <https://ibfmed.ca/referring-mds-nps/>.

Please fax completed forms with relevant PMHx & list of current meds to 647-660-9355