

**Wellness Monitoring for Major Depressive Disorder:**  
*A collaborative investigation of predictors of relapse in major depressive disorder*

**PATIENT REFERRAL FORM**

**DATE OF REFERRAL:** \_\_\_\_\_

Patient's name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
(dd/mmm/yyyy)

Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_

Tel: H(\_\_\_\_\_) \_\_\_\_\_ W(\_\_\_\_\_) \_\_\_\_\_

Health Card Number: \_\_\_\_\_ Version Code: \_\_\_\_\_ MRN: \_\_\_\_\_

**REFERRING PHYSICIAN:** (*Patient must be referred by a physician*)  Family Physician  Psychiatrist

Name: \_\_\_\_\_ Billing Number: \_\_\_\_\_

Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_

Tel: (\_\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

**REFERRAL DETAILS**

**WORKING DIAGNOSIS:** \_\_\_\_\_

**PRESENTLY UNTREATED:**  YES  NO

**CURRENT SYMPTOMS:**

**CURRENT MEDICATION(S):**  NONE

**PAST MEDICATION(S):**  NONE

**MEDICAL ILLNESSES:**  NONE