

## Anxiety Treatment and Research Clinic

St. Joseph's Healthcare Hamilton  
100 West 5<sup>th</sup> Street, Hamilton, ON L8N 3K7  
Phone: (905) 522-1155 ext. 33697  
Fax: (905) 521-6120  
Website: [www.stjoes.ca/anxiety](http://www.stjoes.ca/anxiety)

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Richard P. Swinson, M.D. (Medical Director)  
Martin M. Antony, Ph.D. (Research Director)

- The Anxiety Treatment and Research Clinic (ATRC) offers assessment and treatment for people whose **principal** problems are due to anxiety. We are **not** able to serve people who have primary difficulties with depression and mood disorders, substance use disorders, psychotic disorders, and other problems such as eating disorders.
- Our treatment programs include **group-based** cognitive behavioural therapy for a variety of anxiety disorders and consultation about medication treatments. We also offer social work and occupational therapy services.
- The Anxiety Treatment and Research Clinic offers consultation to referring physicians and time-limited treatment when appropriate. In cases where we cannot provide treatment, additional referral options will be provided to the referring physician
- In cases where we are unable to assess a referred patient, the referring physician will be contacted.
- If you are unsure as to the suitability of a referral to the ATRC please call Judy Odom at 905-522-1155 x33697

### REFERRAL FORM

To refer a patient to the program please complete and return this form by mail or fax. We will contact the patient directly for additional screening by telephone or when an assessment appointment becomes available.

Date of Referral: \_\_\_\_/\_\_\_\_/\_\_\_\_  
dd / mm / yy

Referring Physician / Agency: \_\_\_\_\_

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

\_\_\_\_\_

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

Physician's Billing Number \_\_\_\_\_ Signature \_\_\_\_\_

Patient Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Initial: \_\_\_\_\_

Address (number & street): \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_ HIN Number: \_\_\_\_\_

Tel: Home ( \_\_\_\_ ) \_\_\_\_\_ Work or Cell ( \_\_\_\_ ) \_\_\_\_\_

Date of Birth: d\_\_\_\_m\_\_\_\_y\_\_\_\_ Gender: Male ( ) Female ( ) Transgendered ( ) Intersex ( )

Age: \_\_\_\_\_ Marital status: \_\_\_\_\_ Is patient employed? ( ) Yes ( ) No ( ) Don't know

If employed, occupation of patient \_\_\_\_\_

**[www.stjoes.ca/anxiety](http://www.stjoes.ca/anxiety)**

**Purpose of Referral (check all that apply):**

- |  |  |
|--|--|
| <input type="checkbox"/> Opinion regarding diagnosis and treatment | <input type="checkbox"/> Cognitive Behaviour Therapy |
| <input type="checkbox"/> Medication consultation                   | <input type="checkbox"/> Other: _____                |

**Prominent symptoms (check all that apply):**

- |  |   |
|--|---|
| <input type="checkbox"/> Panic attacks             | <input type="checkbox"/> Distress after a traumatic event       |
| <input type="checkbox"/> Obsessions or compulsions | <input type="checkbox"/> Specific fears (i.e., specific phobia) |
| <input type="checkbox"/> Social anxiety or shyness | <input type="checkbox"/> Other _____                            |
| <input type="checkbox"/> Persistent worrying       |   |

**Which of these is the most disabling problem currently?** \_\_\_\_\_

**Please check all items that apply to this patient:**

- |  |  |
|--|--|
| <input type="checkbox"/> Current substance abuse                       | <input type="checkbox"/> History of violence or legal problems |
| <input type="checkbox"/> Hallucinations or delusions (past or present) | <input type="checkbox"/> Currently has suicidal ideation       |
| <input type="checkbox"/> Suicide attempt ( when? _____ )               | <input type="checkbox"/> Personality disorder                  |
| <input type="checkbox"/> Depression                                    |  |

Brief description of **presenting problem** (attach report if available): \_\_\_\_\_

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**Relevant Medical History** \_\_\_\_\_

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**Is this patient currently in treatment with a mental health professional?**

☐ Yes ☐ No ☐ Don't know If Yes, please name mental health professional: \_\_\_\_\_

**Current Medications** \_\_\_\_\_

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**Has this patient been a psychiatric inpatient?** ☐ Yes ☐ No ☐ Don't know

If Yes, where and when?

Has this patient previously been a patient of St Josephs Healthcare Hamilton? ☐ Yes ☐ No ☐ Don't know

Has this patient previously been seen at the ATRC? ☐ Yes ☐ No ☐ Don't know

*Thank you for referring this patient and completing this form. We will be in contact with them as soon as possible.*