Get Well Clinic
649 Sheppard Ave West
Toronto, ON, M3H 2S4
TEL: (416) 508-5691 | FAX: (416) 398-2436

Referral form for Wait List Application for OHIP Covered Psychotherapy by Dr. Laura Copeland

Full Name	
Date of Birth	
Phone Number	
Email	
Mental Health Diagnosis	( ) Depression ( ) Anxiety ( ) Adjustment Reaction/ Life Stressors ( ) Mood Disorders ( ) Oth- ers:_____

Dr. Copeland requests wait list clients to meet/agree to the following conditions:

Condition	**Please write Yes or No**
Please ask your family physician or psychiatrist to fill out the referral form.	
Please complete the PHQ9 and GAD7 screening tools. For PHQ9 scores greater than 19 and or GAD7 scores of 16 or more, confirm that a referral to a psychiatrist is in place.	
You are prepared to commit to 1 hour a week of therapy for 16 weeks	
You are available for therapy appointments on Fridays between 9am and 5pm	
Confirm Inclusion and Exclusion criteria are met: Inclusion criteria: • Ages 15 or older • Must be willing and able to utilize workbooks and participate in homework Exclusion criteria: • Ages 14 or younger • Unwilling or able to utilize workbooks and participate in therapy homework	

Client Signature:_____

Date: _____

Please mail application forms to Get Well Clinic at 649 Sheppard Avenue West, Toronto ON M3H 2S4, fax to (647) 478-7604, or submit electronically through the follow secure link: https://www.getwellclinic.ca/e-platform-menu/send-file. Thank you.