

Dr. Jessika Schaman, MD, CCFP (AM)
GP Psychotherapist

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FHO clients are welcome: Dr. Schaman has a **focused practice designation in psychotherapy in Ontario**, therefore there is no negation.

Please initial below to acknowledge:

- You have reviewed the inclusion and exclusion criteria and that your patient is an appropriate referral (see the criteria below).
- The patient is aware of and supports the referral.

Initials: _____

Please note: if the referral is not deemed appropriate, you will be notified by fax and the patient will not be contacted.

Inclusion Criteria:

Dr. Schaman offers time-limited psychotherapy (approximately 8 sessions) using a CBT framework to treat the following conditions:

- Generalized Anxiety Disorder
- Panic Disorder
- Social Anxiety Disorder
- Low Self Esteem
- Mild to Moderate Depression
- Insomnia
- People pleasing

Exclusion Criteria:

Given the scope of this clinic and that psychotherapy is provided virtually, the following conditions are **NOT** treated:

- Bipolar Disorder
- Borderline personality disorder
- Psychosis
- Post Traumatic Stress Disorder
- Eating Disorders
- Active suicidal ideation, recent suicide attempts or mental health conditions that have required hospitalization in the past year.
- Active Substance Use Disorder

Please note: We are not able to treat patients who are in crisis or require urgent mental healthcare.

Referral Form:

Patient Information:

First name: _____ Last name: _____

Preferred name: _____

OHIP Number: _____ Version code: _____

Phone: _____ Email Address: _____

* Does patient prefer to be contacted by phone or email: _____

Reason for Referral (Circle all that apply):

- Generalized Anxiety Disorder
- Panic Disorder
- Social Anxiety Disorder
- Low Self Esteem
- Mild to Moderate Depression
- Insomnia
- People pleasing

Psychiatric History:

Diagnoses:

1. _____

2. _____

3. _____

Suicide attempt/ideation: Yes/No mm/dd/yyyy: _____

Self-harming behaviours Yes/No mm/dd/yyyy: _____

Anger issues/violent behaviour Yes/No mm/dd/yyyy: _____

Substance use disorder: Yes/No mm/dd/yyyy: _____

Admission to hospital for mental health treatment: Yes/No mm/dd/yyyy: _____

Pertinent Medical History:

1. _____ 2. _____

3. _____ 4. _____

Medication (or attach list):

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Allergies:

Referring Physician Information:

Name: _____

Phone: _____ Fax: _____

Billing Number: _____