Sunnybrook
FREDERICK W. THOMPSON ANXIETY DISORDERS CENTRE

CLIENT IDENTIFICATION

FREDERICK W. THOMPSON ANXIETY DISORDERS CENTRE
Intensive OCD Program Referral
Supplemental Physician Form

General Inquiries: (416) 480-4002
Referral Status: (416) 480-4426
Fax: (416) 480-5766
Email: thompsoncentreclinic@sunnybrook.ca
Website: www.sunnybrook.ca/thompson

This form is intended to be submitted as part of the Intensive OCD Live-In and Day Treatment Program referral, along with:

- **Severe OCD Services Referral Form**
- **Intensive OCD Program Referral: Supplemental Client Form**
- **Psychiatric consult note or discharge summary from psychiatric admission**

All components must be submitted in order for the referral to be processed.
Refer to the **Severe OCD Services Referral Form** or the Thompson Centre website for full program information and eligibility criteria.

Date (yyyy/mm/dd): _____

PREFERRED FORMAT

☐ **Live-in**
Client resides in treatment facility from admission to discharge.

☐ **Day Treatment**
Client attends treatment Monday-Friday, 9 am to 4 pm while residing at home.

The decision of format will be determined following an intake interview between the client and an Intensive Program staff clinician. The clinician will also discuss availability of in-person and virtual options at time of screen.

Provide a brief history of the client's OCD, including current symptoms:

What is the client's current level of functioning? Can they work/attend school? How impairing is the OCD? Can they perform their activities of daily living (ADL's)?

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Please list any co-morbid psychiatric conditions that may interfere with treatment. Please note current state of these conditions:

Is there any current/past substance abuse history, including any treatment for substance abuse?

Does the client have any history of acting violently or demonstrating aggressive behavior? Any legal issues?

Does this client have a history of impulsive or self-injurious urges? If so, what are these behaviors? What coping skills has he/she learned to try to manage the urges?

Has this client ever attempted suicide in the past? Please provide details (i.e., when did this occur, method of attempt?)

Is there any current suicidal ideation? If so, please describe.

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Please tell us about the client's current support system and living situation. Is their living situation stable and can they return there after treatment?

How involved is the client's family in their care? Does the family accommodate the client's OCD (i.e., provide reassurance with respect to their obsessions and or compulsions; do they participate in rituals for the client?)

MEDICAL AND TREATMENT HISTORY
Please provide information about the client's medication history (if applicable), including any medical issues and what type of care is required to manage them.

How motivated do you feel your client is to engage in an intensive and demanding treatment program at this time? Please describe.

What do you identify as barriers to this client's ability to benefit from and participate in treatment (i.e., interpersonal style; level of insight into symptoms, ability to grasp skills and concepts; significant cognitive challenges; secondary gains)?

Version December 2022