INSPIRED LIVING MEDICAL
LIVE YOUR EPIC LIFE

Dr. E. Adriana Wilson, MD, FRCPC
Psychiatrist
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620 Nine Mile Drive, Unit 208
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ELECTRONIC CORRESPONDENCE AGREEMENT

Inspired Living Medical (ILM) will make reasonable efforts to protect the security and privacy of information sent and received via email, however, **we cannot guarantee** the security and confidentiality of electronic communications.

- It is our duty to uphold the standards of the Personal Health Information Act (PHIA), and the Personal Information Protection and Electronic Documents Act (PIPEDA).
- Your email address will be securely stored in your chart within ILM's Electronic Medical Record. Email correspondence is stored within ILM's Canadian hosted email server for approximately 1 year, subject to storage capacity limitations. Relevant care-related emails are uploaded to your chart and retained per our policies.
- We do not currently use encrypted emailing.
- Your email address will not be used for any purpose other than direct correspondence about your care at ILM, or research study opportunities.
    - Dr. Adriana Wilson periodically leads research studies. We may send you a recruitment email, in which Dr. Wilson would be looking for volunteers to join a research study. If you wish to opt out of any research opportunities, please indicate this below.
- Email attachments from ILM containing personal health information are password protected. Please be mindful of protecting your personal health information when sharing via email or otherwise.
    - Example: Before emailing us your completed intake form, you may wish to password protect the document and call us (or leave a message) and provide the password.
- You should consider who has access to your email account when choosing an email address for us to correspond with (e.g. some employers reserve the right to monitor work email addresses).
- Email accounts with servers outside of Canada (*e.g. Gmail.com, Hotmail.com, etc.)* are subject to other countries' privacy laws. *For example, the USA's PATRIOT Act permits U.S. law enforcement officials to request a court order to access the personal records of any person for the purpose of an anti-terrorism investigation, without that person's knowledge.* Therefore, we cannot guarantee confidentiality.
- We ask that you clearly identify your name as it is presented on your provincial health card somewhere in the body of your email. This helps to protect against identity confusion.

I (patient) understand and accept the risks associated with the use of electronic communication with ILM, including the sharing of my medical records and reports via email. I agree to communicate with ILM clinicians/staff by electronic methods with a full understanding of the risks involved. Any questions I had have been answered.

I acknowledge that either I or the physician may, at any time, withdraw the option of communicating electronically through the Services upon providing written notice.

Patient Name: _____ **DOB (MM/DD/YYYY):** _____

Signature of Acknowledgement: _____ **Date:** _____

Your Email: _____

☐ **Do NOT contact me for any research study opportunities.**

Please note: This first page is a consent form which allows us to correspond with you ongoing via email, and must be completed in order to receive a digital copy of your report. This is only mandatory if you wish to have a digital copy of your report and/or communicate via email. Reports are always faxed to your referring physician.

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ATTENTION

New ADHD Process Update

If you would like Dr. Adriana Wilson to assess you for Attention Deficit Hyperactivity Disorder (ADHD) as a part of this consultation appointment, we require ADHD Collateral information. Instructions on what collateral we require can be found at: www.InspiredLivingMedical.com/ADHD

- If you do not suspect ADHD, are not interested in being assessed for ADHD, or have a previous diagnosis of ADHD then you DO NOT need to submit Collateral Information.
- If you do not submit the required Collateral Information then Dr. Wilson cannot fully assess for ADHD as a part of this appointment.
- Dr. Wilson is still able to see you for a comprehensive psychiatric consultation in which she will screen for other mental health-related diagnoses, and provide you with diagnostic clarification and a treatment plan.
- Please note: Dr. Wilson is unable to accurately assess ADHD in the context of learning disorder (e.g. Dyslexia, Processing Disorders etc.) or significant mental illness dating back to childhood. These circumstances require psychoeducational testing or a referral to a specialty ADHD clinic to tease these conditions apart.

Please visit our website for more information:

www.InspiredLivingMedical.com/ADHD

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INTAKE FORM

Filling out the intake form:

- Please complete to the best of your ability and **return at your earliest convenience.** Most questions are check boxes and long answers are not necessary. You will have a chance to elaborate during your consultation appointment.
- Once you have completed your intake form, you may email it as an attachment to info@inspiredlivingmedical.com, or fax/mail it to the information above. You may wish to consider password protecting your digital intake form.
- Once received, we can add you to the cancellation list if indicated. Please see our website for current wait times.
- Your completed intake form is due 3 months after receiving your New Patient Letter. If we do not receive it, we will make 2 attempts to contact you. If we do not hear back after this, we will assume you are no longer interested in this appointment and return the referral back to your referring clinician. Please reach out if you require more time.

What to expect from the appointment:

- This referral is for a **one-time** appointment that typically lasts 2 hours. There will not be follow up appointments.
- At the end of this appointment, Dr. Wilson will review any diagnoses and recommendations for therapy, medication, or other interventions . The report will be sent to your referring clinician who can follow up on the recommendations. Implementation and follow up happens with your GP/ NP, in combination with the resources that are recommended.
- Appointments are offered in-person or virtually (Zoom video or telephone), please indicate below your preference.
  - YOU MUST BE PHYSICALLY IN Nova Scotia at the time of virtual appointments.
- *Should your symptoms worsen, please contact your GP or NP, present to the nearest Emergency room or contact the Mobile Crisis Team at 902-429-8167 for assessment.*

Payment, cancellations, and late arrivals policy:

- The cost of this appointment is covered by the provincial health plan (MSI) as long as your health card is valid. **Please check your expiration date prior to your appointment**. Please have your card with you at your appointment.
- A fee of **$240 is charged when less than 2 business days of notice is provided for a cancellation** of your appointment.
- After **15 minutes of tardiness**, your appointment will be **rescheduled** and the full cost of the late will will be charged.
- Our automated appointment reminder system will send you a message 1 week prior to your scheduled appointment to help avoid late cancellation fees, please indicate below how you would like to receive this reminder.

Your NAME:	**Date Completed:**
Date of Birth (YYYY/MM/DD):	**Preferred Pronouns:** ☐ **He/Him** ☐ **She/Her** ☐ **They/Them**
Health Card #:	**Health Card Expiry Date:**
Family Doctor's name:	**Family Doctor Phone number and Clinic Location:**
Your Preferred Appointment type: *(If you choose virtual & in person, you will be scheduled for whichever is sooner)* ☐ **In-Person** ☐ **Zoom Video Call*** ☐ **Telephone Call*** *If virtual, please review the virtual consent video on our web-site (https://www.inspiredlivingmedical.com/Intake) ☐ **I have watched the video and consent to virtual care**	**Appointment Reminder will be sent via** *(choose only one):* ◯ **Email** ◯ **Text message** ◯ **Automated phone call** **Confirm email/phone #:** Add me to cancellation list: ☐ Yes

What are the main concerns that you are struggling with that you hope this appointment can help address?

PERSONAL HISTORY

- **Where were you born?**
- **If you moved during childhood, where else did you live while growing up?**
- **Who would you say raised you?**
- **Are your parents**: ☐ Together ☐ Separated**/**Divorced ☐ Deceased *Details:*
- **What did your caregivers do for work/income?**
- **Briefly, how would you describe your childhood?**
- **How many siblings do you have?**
  - **Briefly describe your relationship with them** (if applicable)**:**
- **Generally, describe your relationship with your parents:**
- **How was conflict handled in your home growing up:** ☐ Talking things through **/** ☐ Yelling **/** ☐ Violence / ☐ Silent treatment/ ☐ Loss of privileges **/** ☐ Pretending nothing happened (ignoring/avoiding) / ☐ Other**:**
- **In my home growing up, affection was shown by**: ☐ Hugs **/** ☐ Kisses **/** ☐ I love you's / ☐ Words of affirmations **/** ☐ Gifts **/** ☐ Eating meals together **/** ☐ Spending time together **/** ☐ Emotional support / ☐ Other**:**
- **What is your highest level of education?**
- **Please list your employment/work history:**
  - **Which work position has been your longest, and for how long?**
- **Please describe your sexual identity** *e.g. heterosexual, bisexual, gay/lesbian etc.***:**
- **How long was your longest romantic relationship?** ☐ Current
- **Please list history of any long term relationships, marriages, divorces:**
- **How long was your longest romantic relationship?**
- **Currently, who are your supports or people you can lean on?**

Please finish the following sentences:

- **My strengths are:**
- **My sense of purpose comes from:**
- **My sense of meaning, like I am contributing to something beyond myself, comes from:**
- **My creative outlets include:**
- **My sense of challenge comes from:**

Comments, Observations or Concerns from Your Loved Ones: *You may wish to include comments, observations, or concerns from your loved ones separately enclosed with this intake.*

Please answer the following questions based on the past 2-3 weeks unless otherwise specified.

My **MOOD** through most of my adult life has been ___/10 (*1= so low can barely get out of bed; 10= happy go lucky*)

- My mood in the past few weeks has been ___/10
- **When** and **why** do you think it changed?

SLEEP: I fall asleep ☐ Quickly (within 30 mins) **/** ☐ It takes 1 hour or more / ☐ It changes night to night.
What time do you typically go to sleep?___ Wake up? ___ #Times you wake during sleep:___ for ___mins each time.
I snore: ◯ Yes ◯ No I have diagnosed sleep apnea: ◯ Yes ◯ No If yes, I use a CPAP regularly: ◯ Yes ◯ No

Things that I typically **ENJOY** doing**:**
I have been enjoying these as usual lately: ◯ Yes ◯ No

I have been prone to **GUILT & NEGATIVE THINKING** throughout my life: ☐ Yes ☐ No
Negative thinking has been ◯ Worse **/** ◯ Better **/** ◯ The same as usual in recent weeks.
The change is due to:

My **ENERGY** at baseline is ◯ Similar **/** ◯ Lower **/** ◯ Higher compared to other people my age, and recently my energy is ◯ Worse **/** ◯ Better **/** ◯ The same as usual. I get **physical exercise**: ___ # of times/ week.

FUNCTION:
Currently the following areas are worse than my usual: ☐ Hygiene **/** ☐ Cooking **/** ☐ Basic housekeeping / ☐ Working **/** ☐ Grocery shopping **/** ☐ Paying bills / ☐ Managing medications **/** ☐ Driving / ☐ Leaving the house.

CONCENTRATION at my baseline is ___/10 and recently it is ___/10 *(1= very low, 10= great)*
I have a formal diagnosis from a doctor/mental health professional of a ☐ Learning disorder ☐ ADD/ADHD ☐ None.

My **APPETITE** has been ☐ Stable **/** ☐ Lower than usual **/** ☐ Higher than usual / ☐ Variable **/** ☐ Eating emotionally/ boredom.
In the last 12 months, my weight has: ☐ No change / ☐ Weight Gain **/** ☐ Weight loss / ☐ Intentional : How much
My usual adult height is ___ and weight is: ___. I eat 5+ servings of fruit/vegetables daily: ◯ Yes ◯ No

COPING
I have ◯ Never **/** ◯ Occasionally **/** ◯ Often had thoughts I would be better off dead or plans to kill myself.
I ◯ Have/ ◯ Have not had PRIOR SUICIDE ATTEMPTS. If yes, how many and when?
I ◯ Have/ ◯ Have not engaged in SELF HARM (e.g. hitting, burning, cutting). If yes, how and when?

LEGAL HISTORY: I have ☐ No **/** ☐ Current **/** ☐ Past legal charges or time served.
If yes, what were the charges and when?

I ◯ Have/ ◯ Have not had a serious plan and intention to kill someone else currently or in the past.

I ◯ Have/ ◯ Have not had **PAST EPISODES** of depression. If so, when?
I ◯ Have/ ◯ Have not had a psychiatric **HOSPITALIZATION.**

AT BASELINE I chronically struggle with: ☐ Low mood (2+ yrs) **/** ☐ Sleep issues **/** ☐ Appetite issues / ☐ Low energy **/** ☐ Difficulty with concentration ☐ Indecision **/** ☐ Feelings of hopelessness **/** ☐ Low self esteem / ☐ None of these.

MANIA

☐ I have had periods of 4 consecutive days or more when my mood was abnormally high or irritable AND I was only sleeping 2-3h/ night AND I did not feel tired AND I was acting in unusual ways that were commented on by others. (Specify details including when and how often):

☐ I have had times when I wondered if I was seeing or hearing things other people did not see or hear. Please provide details:

OCD

Please indicate if you feel you get stuck in, or preoccupied with, routines or thoughts involving *(check all that apply, if any):*

- ☐ Concerns about contamination, cleaning/ washing
- ☐ Ordering/ arranging
- ☐ Hoarding items without sentimental value (empty envelopes, old clothes)
- ☐ Repeating rituals (re-reading emails, re-writing things until it feels "just right")
- ☐ Checking rituals (doors, windows, stove, faucets, etc.)
- ☐ Reassurance seeking
- ☐ Counting rituals
- ☐ Excessive list making (stops being helpful)
- ☐ Aggressive or sexual intrusive thoughts

GENERAL ANXIETY

Do you feel that you **worry more than is appropriate** for your situation AND it interferes with your life? ◯ Yes ◯ No

If yes, **what do you tend to worry about:**

For you, is **worry is associated with**: ☐ Tension **/** ☐ Sleep difficulty **/** ☐ Fatigue / ☐ Concentration difficulties **/** ☐ Irritability / ☐ Mind going blank / ☐ Feeling restless.

I drink **coffee, tea, pop or energy drinks** ____ times/ week or ____ times/ day. I eat **chocolate** ____ times/ week.

PANIC

Please check all that apply:

- ☐ **I have had sudden onset of panic that came on suddenly and left in 20-30 min**
- ☐ **It happened** ____ **times** ***or*** ____ **times/ week**
- ☐ **I worry it will happen again**

If yes, the panic was associated with: ☐ Feeling of impending doom **/** ☐ Chest tightness **/** ☐ Shortness of breath / ☐ Stomach upset **/** ☐ Numbness or tingling/ ☐ Sweating a lot / ☐ None of these.

SOCIAL ANXIETY

Please check all that apply:

- ☐ I feel **anxious** in **social situations**
- ☐ I worry about being **judged**, being **ridiculed**, or being **embarrassed**
- ☐ The social anxiety **interferes with my ability to function in my life** (please specify how):

HEALTH ANXIETY

Please check all that apply:

- ☐ I worry **more than most** about my **physical health**
- ☐ I am **easily alarmed** by **physical symptoms**
- ☐ This worry **interferes with my life**
- ☐ I tend to get **physical symptoms** when I am **stressed** (*please indicate which, i.e., IBS, migraines, headaches requiring medicine or time off work*):

TRAUMA

Please check all that apply to you:

- ☐ I have felt my life was threatened
- ☐ I witnessed someone else's life be threatened
- ☐ I experienced sexual abuse or assault

If positive for any of the above, **please include approximate dates or ages at time of trauma:**

Please check all that apply to you regarding this event(s):

- ☐ I have intrusive thoughts, memories or dreams related to these/ this event(s)
- ☐ I get physically distressed when I think or am reminded of them
- ☐ I avoid thinking or talking about them
- ☐ I avoid people, places or reminders of the event(s)
- ☐ I feel these events still impact my life (specify how):

SUBSTANCE USE

Please check the box for each substance you have ever used. For positive answers, please indicate your current amount of use and peak amount of use for how long (e.g. 1 bottle of wine/week for 6 months).

- ☐ **Alcohol**
  Current use**:** Peak of use**:**
- ☐ **Cannabis**
  Current use**:** Peak of use**:**
- ☐ **Tobacco**
  Current use**:** Peak of use**:**
- ☐ **Opioids** *(Oxy, Dilaudid, Fentanyl, etc.)*
  Current use**:** Peak of use**:**
- ☐ **Cocaine or stimulants** *(Adderall, Ritalin, etc.)*
  Current use**:** Peak of use**:**
- ☐ **Hallucinogens** *(LSD, mushrooms, etc.)*
  Current use**:** Peak of use**:**
- ☐ **Benzodiazepines** *(Xanax, Ativan, Clonazepam, etc.)*
  Current use**:** Peak of use**:**
- ☐ **Other prescription drugs** *pls specify*:
  Current use**:** Peak of use**:**
- ☐ **Other non-prescription drugs** *pls specify*:
  Current use**:** Peak of use**:**

Please list the substances, if any, that you feel have been an issue for you at some point:

With regard to these substances above that you listed, please check all that apply to you: *If positive responses for multiple substances, please place the first letter of the substance next to each of the relevant check boxes.*

- ☐☐ Used it in **larger amounts** than intended or **over a longer period** than intended
- ☐☐ Had a **desire** or **unsuccessful efforts** to cut down or control its use
- ☐☐ Spent **a lot of time** in activities to **get it, use it** or **recover** from it
- ☐☐ Had **cravings** or strong urges to use the substance in question
- ☐☐ Recurrent use **impacting obligations at home, work** or **school**
- ☐☐ Continued use despite it **causing or worsening relationship issues with family, friends or co-workers**
- ☐☐ Important **social, occupational, or recreational activities being given up** or **reduced** because of it
- ☐☐ Use in situations where it is **dangerous** *(i.e. Driving, working etc.)*
- ☐☐ **Physical** or **mental condition worsened** by its use
- ☐☐ **Tolerance** *(need more to feel the effect or less effect with same amount)*
- ☐☐ **Withdrawal** *(Or use to <u>avoid</u> withdrawal)*

ATTENTION

Please check all that apply to you:

- ☐ History of inattention dating back to elementary school
- ☐ Making careless mistakes
- ☐ Difficulty staying focused
- ☐ Seemingly not listening when spoken to
- ☐ Difficulty following through on instructions or completing work in allotted time
- ☐ Difficulty staying organized
- ☐ Poor time management
- ☐ Avoiding tasks that required sustained attention (procrastination)
- ☐ Often losing things
- ☐ Easily distracted
- ☐ Often forgetting things (i.e., appointments, pay bills etc.)
- ☐ History of being fidgety
- ☐ Needing to leave my seat and walk around
- ☐ Running about or climbing as a child in inappropriate situations
- ☐ Talking excessively
- ☐ Blurting out answers as a child and having difficulty waiting my turn
- ☐ These behaviors started before the age of 12
- ☐ These behaviors happen in 2+ settings (e.g. School, home)

If you would like to be assessed for ADHD, please <u>also</u> submit the required ADHD Collateral Forms found at www.InspiredLivingMedical.com/ADHD

PERSONALITY FEATURES

Please check all that apply to you:

- ☐ Sensitivity to abandonment or rejection
- ☐ Feelings of emptiness
- ☐ Lots of drama in my relationships
- ☐ Mood being really up and down even within the course of a single day
- ☐ Issues with anger
- ☐ Losing myself when in relationships (taking in their interests and dropping my own)
- ☐ Impulsivity (with money, sex, job changes, alcohol, food, drugs, relationships)
- ☐ Longstanding suicidal thoughts
- ☐ Longstanding history of self-harm
- ☐ Need to inflate my sense of self-importance, often at other people's expense
- ☐ Struggle to make decisions on my own, need to people please even when it is bad for me.
- ☐ History of illegal activity *(15 yo or younger)*
- ☐ Disregard for my own or other people's safety
- ☐ Difficulty holding a job or honoring my commitments
- ☐ Frequent lying to serve my needs
- ☐ Repeated physical fights or assaults

CURRENT MEDICATIONS (*Please answer the following to the best of your ability and leave unknown answers blank)*

MEDICATION	DOSE	HOW LONG at this dose?	RESPONSE	SIDE EFFECTS

DEVELOPMENTAL HISTORY (*Please check all that apply and provide details*)

- ☐ Issues when your mother was pregnant with you (physical abuse, health issues like drinking, illness)? *Please provide details:*
- ☐ Complications at birth. *Please provide details:*
- ☐ Health issues in the first few months after birth? *Please provide details:*
- ☐ Concerns about your development, like when you talked, walked, your coordination or social skills? *Please provide details:*
- ☐ Difficulties with learning (i.e., Math difficulties, repeating a grade etc.) *Please provide details:*
- ☐ Social difficulties? *Please provide details:*

ALLERGIES

Please list any drug and non-drug allergies:

☐ **No known drug or non-drug allergies**

PAST MEDICAL HISTORY

Please list any surgeries you have had: *(Wisdom teeth, Appendicitis, Gallbladder removal, C-sections, Hysterectomy, etc.)*

☐ **No history of surgeries**

PAST MEDICAL HISTORY

Please check if you have a history of, or currently struggle with any of the following:

- ☐ Anemia (low iron)
- ☐ Vitamin B12 deficiency
- ☐ Low testosterone
- ☐ Sleep apnea
- ☐ Thyroid problems
- ☐ Seizures
- ☐ Head injuries with loss of consciousness
- ☐ Diabetes
- ☐ Heart issues
- ☐ Blood pressure

Do you routinely see a doctor or NP for any other reason?

- ◯ **No**
- ◯ **Yes,** *please provide details:*

PAST MEDICATION TRIALS:

Check all that apply and if possible, bring information about your max dose and duration of use to your appointment.

- ☐ Cipralex/ Escitalopram
- ☐ Celexa/ Citalopram
- ☐ Prozac/ Fluoxetine
- ☐ Zoloft/ Sertraline
- ☐ Luvox/ Fluvoxamine
- ☐ Paxil/ Paroxetine
- ☐ Strattera/ Atomoxetine

- ☐ Fetzima/ Levomilnacipram
- ☐ Effexor/ Venlafaxine
- ☐ Pristiq/ Desvenlafaxine
- ☐ Cymbalta/ Duloxetine
- ☐ Trintellix/ Vortioxetine
- ☐ Viibryd/ Vilazodone
- ☐ Wellbutrin/ Bupropion

- ☐ Mirtazipine/ Remeron
- ☐ Trazodone/ Desyrel
- ☐ Elavil/ Amitriptaline
- ☐ Desipramine/ Norpramin
- ☐ Aventyl/ Nortriptaline
- ☐ Anafranil/ Clomipramine
- ☐ Tofranil/ Imipramine

- ☐ Imovane/ Zopiclone
- ☐ Ambien/ Zolpidem
- ☐ Ativan/ Lorazepam
- ☐ Klonopinl/ Clonazepam
- ☐ Xanax/ Alprazolam

- ☐ Lamictal/ Lamotrigine
- ☐ Lithium
- ☐ Valproic Acid
- ☐ Epival/ Divalproate

- ☐ Seroquel/ Quetipaine
- ☐ Abilify/ Aripiprazole
- ☐ Risperdal/ Risperidone
- ☐ Zyprexa/ Olanzapine
- ☐ Zeldox/ Ziprazidone
- ☐ Latuda/ Lurasidone
- ☐ Sapharis/ Asenapine

- ☐ Ritalin
- ☐ Biphentin
- ☐ Concerta
- ☐ Dexedrine
- ☐ Adderall XR
- ☐ Vyvanse
- ☐ Foquest

☐ Other **psychiatric** medication not listed: _____

PAST THERAPY TRIALS

In the past, I have seen:

- ☐ Psychiatrist
- ☐ Psychologist
- ☐ EAP (Employee Assistance Program) or Social Work
- ☐ Outpatient Day Treatment Program (multidisciplinary team)
- ☐ Other (specify): _____
- ☐ I have a current therapist *please provide their name*: _____

For positive responses to above, in the past I have found therapy to be:

- ◯ Helpful
- ◯ Not helpful

APPROACH USED

- ☐ Don't know
- ☐ Supportive and/ or solutions/ problem-oriented
- ☐ Cognitive Behavior Therapy (CBT)
- ☐ Acceptance and Commitment Therapy (ACT)
- ☐ Eye Movement Desensitization Reprocessing Therapy (EMDR)
- ☐ Intensive Short Term Dynamic Psychotherapy (ISTDP)
- ☐ Dialectic Behavior Therapy (DBT)
- ☐ Emotion Focused Therapy (EFT)
- ☐ Marital Therapy

FAMILY MEDICAL HISTORY (blood relatives only)

These illnesses run in my family *(check all that apply):*

- ☐ Diabetes
- ☐ Heart disease or sudden death at an early age
- ☐ Cancer *if so, which type:* _____
- ☐ Other**:** _____

FAMILY PSYCHIATRIC HISTORY (blood relatives only)*:*

Please check all that apply for known family diagnoses:

- ☐ Addiction
- ☐ Depression
- ☐ Bipolar
- ☐ Social Anxiety
- ☐ Generalized Anxiety
- ☐ Panic Disorder
- ☐ OCD
- ☐ PTSD
- ☐ ADHD or ADD
- ☐ Autism
- ☐ Psychosis or schizophrenia
- ☐ Early dementia (before 65)
- ☐ Completed suicides

Thank you for taking the time to complete this form as accurately as possible.
I look forward to meeting with you to discuss things further and see how I may be of help to you.

I suggest you check out our website for Resources while you wait for your appointment, www.InspiredLivingMedical.com. It includes a "Therapists in Halifax" page for those seeking to start treatment while they wait. There are also various resources available that may be helpful. Should your symptoms worsen, please contact your GP or NP, present to the nearest Emergency room or contact the Mobile Crisis Team at 902-429-8167 for assessment.

Warmest wishes,
Dr. E. Adriana Wilson