

Refer to: _____

REFERRAL FORM

PATIENT INFORMATION

Patient's Name: _____ DOB: _____ Gender: _____
MM/DD/YYYY

Patient's Address: _____ Phone: _____

Health Card #: _____ Health Card Expiry: _____
MM/DD/YYYY

E-mail: _____ Date: _____
MM/DD/YYYY

Is the patient a veteran? Y ☐ N ☐

Caregiver Name (If Applicable): _____

Caregiver Phone #: _____ Caregiver E-mail: _____

Reason for Assessment: ☐ Pain ☐ Anxiety ☐ Sleep ☐ Depression ☐ Cancer ☐ Fibromyalgia ☐ PTSD ☐ Other

Current medical conditions (please provide a copy of medical records, including consults + prior treatments and list any current medication)

☐ History of Bipolar
☐ History of Schizophrenia
☐ History of Psychosis

REFERRING HEALTHCARE PROFESSIONAL

Healthcare Professional name (print) _____ Healthcare Professional signature _____ Billing # (If applicable) _____

Healthcare Professional phone: _____ Fax: _____

Address: _____ E-mail: _____