

Referral Form

Toll Free Phone: 1 (888) 282 7763
Toll Free Fax: 1 (844) 320 9652

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Patient Information:

Name: _____ Date of Birth: _____ Health Card # _____
(MM/DD/YYYY)
Address: _____ City: _____ Postal Code: _____
Phone: (H) _____ (C) _____ (W) _____ Email: _____

Reason for Referral:

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Cancer (please specify) _____ | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Immunological condition (please specify) _____ | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Neurodegenerative disease (please specify) _____ | <input type="checkbox"/> PTSD |
| <input type="checkbox"/> Multiple sclerosis (pain/spasticity) | <input type="checkbox"/> Other _____ |

Does Patient Have:

- Schizophrenia/psychosis Unstable cardiac disease Ongoing substance abuse

Are you a member of a FHO/FHN/FHT? (Ontario Physicians ONLY) Yes No

Referring Physician / Referral Source:

Name (Please Print): _____ Billing Number: _____
Address: _____
Phone Number: _____ Fax Number: _____
Email Address: _____ Signature: _____

Please select clinic location:

- | | | | |
|--|---------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Barrie, ON | <input type="checkbox"/> Edmonton, AB | <input type="checkbox"/> Niagara Falls, ON | <input type="checkbox"/> Toronto, ON |
| <input type="checkbox"/> Brampton, ON | <input type="checkbox"/> Halifax, NS | <input type="checkbox"/> Oakville, ON | <input type="checkbox"/> Vaughan, ON |
| <input type="checkbox"/> Calgary, AB | <input type="checkbox"/> Hamilton, ON | <input type="checkbox"/> Oshawa, ON | |
| <input type="checkbox"/> Cambridge, ON | <input type="checkbox"/> Kingston, ON | <input type="checkbox"/> Ottawa, ON | |
| <input type="checkbox"/> Courtenay, BC | <input type="checkbox"/> London, ON | <input type="checkbox"/> St. John's, NL | |