

PATIENT INFORMATION:

Patient Name: _____ HC#: _____

DOB: ____ / ____ / ____ Sex: _____ Gender: _____ Pronouns: _____
DD MM YYEmail: _____ ☐ No Email

Home Phone: _____ Mobile Phone: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

REFERRAL INFORMATION:

Referring Practitioner: _____ PRAC ID#: _____

Referring Clinic Name: _____ Phone: _____

Address: _____ Fax: _____

City: _____ Province: _____ Postal Code: _____

Referring Practitioner's Signature: _____

REASON FOR REFERRAL:

INFORMATION REQUIRED IN RETURN (click all that apply):

- | | | |
|---|---|--|
| ☐ Referral acceptance letter | ☐ Appointment updates | ☐ Chart notes |
| ☐ Recommendations | ☐ Dosage or g/day | ☐ All of the above |
| Receive Updates by: ☐ Email ☐ Phone ☐ Fax | | |

The content of this communication, including any attachments, is considered confidential, privileged or otherwise exempt from disclosure. It is intended only for the person(s) to who it is addressed and any further distribution is strictly prohibited without the consent of the original sender. If you have received this message in error, please immediately notify the sender and delete this communication. Thank you.