



Referral Form

Fax to (613) 729-9065

OR

Drop off at 1111 Wellington St. West, Ottawa

Patient Information

Name:

Health Card #:

Street Address:

Telephone #:

City/Province/Postal Code:

Date of Birth (MM/DD/YYYY):

Can a voice message be left at this number to schedule an appointment?

Yes

No

Patient Diagnosis and Symptoms:

Current Treatments/Medications:

Previously Used Treatments/Medications:

Other Relevant Medical Information:

Reminder Checklist

(Required)

Referral form completed by
Licensed Physician

(Supplementary)

Additional Medical Documents
supporting client diagnosis

(Supplementary)

Prescription and treatment
history for anything not
described on the Referral Form

A consultation appointment will be scheduled once ALL the requested information has been received and reviewed.

Referring Physician: _____ Provincial Billing #: _____

Address: _____

Telephone: (____) ____ - _____

Fax: (____) ____ - _____

Signature: _____

Date (MM/DD/YYYY): ____ / ____ / ____

let's talk **answers**