Physician Referral Form

Please fax referrals to: (905) 415-9874 PHIPA compliant

Patient Information:

Name _____ Phone _____

Email _____

Address _____

DOB (M/D/Y) _____ Gender _____

Preferred Method of contact: ⬜ Phone ⬜ Email

Referring Physician Information:

Name _____ CPSO # _____

Phone _____ Fax _____

Clinic Address

_____

Please select from the following options. The patient is presenting issue(s) of:
⬜ Anxiety ⬜ Depression ⬜ ADHD ⬜ Addiction ⬜ Grief ⬜ Stress ⬜ Burnout
⬜Couples Counselling ⬜Parenting ⬜Perinatal/Postnatal therapy
⬜Other: _____

Other Additional information:

Physician Signature: _____
Date: _____

Our Office Information

7030 Woodbine Ave Markham, On Phone: (905) 418-2028 Fax: (905) 415-9874