hybridpharm

REFERRAL Form

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PATIENT INFORMATION

First Name(s): _____ Last Name: _____

Birth Date: [M]_____ [D]_____ [Y]_____ Gender: ☐ Male ☐ Female ☐ N/A

Health Card #: _____ *(Veterans please enter K#) Exp:* _____

Phone #: _____ Email: _____

Patient Diagnosis and Symptoms:

_____

_____

_____

Current Treatment / Medications:

_____

_____

_____

Other Relevant History / Information:

_____

_____

Past Medical Treatments:

_____

_____

HEALTH CARE PRACTITIONER INFORMATION

First Name(s): _____ Last Name: _____

Profession: _____ License #: _____ Province Authorized to Practice in: _____

Address: _____ City: _____ Postal Code: _____ Province: _____

Phone #: _____ Fax #: _____ Email: _____

REFERRAL CHECKLIST

☐ Referral form completed *(Required)*

☐ Additional Medical Documents supporting client diagnosis *(Supplementary)*

☐ Prescription and treatment history for anything not described on the Referral Form *(Supplementary)*

SIGNATURES:

Physician Signature : _____ **Date** (M/D/Y): _____