HYBRID PHARM™
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Referral Form

Patient Information

First Name(s): _____ **Last Name:** _____

Birth Date: M _____ D _____ Y _____ **Gender:** ◯ Male ◯ Female ◯ N/A

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

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:** _____ **Postcode:** _____ **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)

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