REFERRAL FORM

EKOSI HEALTH CENTRE

PATIENT INFORMATION:

NAME (FIRST, LAST): _____

HEALTH CARD NO. : _ _ _ _ _ _ _ _ _ _ _ _ VC: _ _ _ DOB - MM/DD/YYYY: _____

9 DIGITS, MANITOBA | 10 DIGITS, ONTARIO + VC — ONTARIO ONLY

EMAIL (REQUIRED): _____

ADDRESS: _____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

PHONE (PRIMARY): _____ PHONE (SECONDARY): _____

PHARMACIST NAME & CONTACT INFORMATION: _____

INDICATION(S):

☐ PAIN ☐ MOOD ☐ SLEEP ☐ OTHER

_____

_____

CURRENT MEDICATIONS / TREATMENTS:

_____

_____

POTENTIAL MENTAL HEALTH CONTRAINDICATION(S):

Has the patient been assessed by a Psychiatrist, GP/Psychotherapist or Clinical Psychologist? ..... ☐ YES ☐ NO

Does this patient have uncontrolled psychosis or mania? ..... ☐ YES ☐ NO

Does the patient have an untreated Substance Abuse Disorder? ..... ☐ YES ☐ NO

REFERRING PRACTITIONER INFORMATION:

REFERRING PRACTITIONER NAME: _____

PROFESSION: _____ BILLING NO. : _____

BUSINESS ADDRESS: _____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

PHONE: _____ FAX: _____

SIGNATURE OF REFERRING PRACTITIONER: _____

DATE SIGNED - MM/DD/YYYY: _____