REFERRAL FORM

EKOSI HEALTH CENTRE

REFERRING TO: ☐ DR. SHELLEY TURNER ☐ DR. JENNIFER ANDERSON ☐ DR. MICHELE MATTER

PATIENT INFORMATION:

NAME (FIRST, LAST): _____

PHIN: _____ (9 DIGITS) REG#: _____ (6 DIGITS) DOB - MM/DD/YYYY: _____

EMAIL (REQUIRED): _____

ADDRESS: _____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

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

PHARMACIST NAME & CONTACT INFORMATION: _____

I AM REFERRING THE PATIENT FOR:

☐ MEDICAL CANNABIS (CANNABINOID THERAPY) ☐ SUBSTANCE USE (ORT)

PLEASE ATTACH MEDICAL HISTORY (INCLUDING CURRENT MEDICATION LIST):

_____

_____

_____

_____

CONSULTANTS:

NAME: _____ NAME: _____ NAME: _____

DESIGNATION: _____ DESIGNATION: _____ DESIGNATION: _____

PHONE: _____ PHONE: _____ PHONE: _____

☐ CURRENT? ☐ CURRENT? ☐ CURRENT?

REFERRING PRACTITIONER INFORMATION:

REFERRING PRACTITIONER NAME: _____

PROFESSION: _____ BILLING# : _____

BUSINESS ADDRESS: _____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

PHONE: _____ FAX: _____

SIGNATURE OF REFERRING PRACTITIONER: _____

DATE SIGNED - MM/DD/YYYY: _____

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