Get Well Clinic
649 Sheppard Ave West
Toronto, ON, M3H 2S4
TEL: (416) 508-5691 | FAX: (647) 478-7604

REFERRAL FORM:

PATIENT INFO:

Name: ________________________________ *
Date of Birth: ______________________ (dd-mm-yyyy)
Gender: __________
OHIP #: ___________________ * Version: ________ *
Address: ___________________________
____
City: _______________ Postal Code: ___________
Phone: _____________________ *
Cell: _____________________
Email: _____________________
(personal, non-work)

(* Required fields)

Reason for Referral:

Past Medical and Psychiatric Health:

Current Medications:

Mental Health:
[ ] Psychotherapy

Child & Youth:
[ ] Behavioural Analyst

Rehab Clinic:
[ ] Chiropractic / Acupuncture
[ ] Physiotherapy

Nutrition & Weight Loss:
[ ] Nutritionist / Dietitian

Foot Clinic:
[ ] Chiropody / Foot Clinic
[ ] Compression Stockings
[ ] Custom Orthotic Insoles

Genetic Testing & Free Consults
[ ] Comprehensive Health Check Test
[ ] Drug Compatibility Test
[ ] Cannabis Sensitivity Test

[ ] *MVC Care*

Physician Referral Required: #
[ ] MD Mental Health/Psychotherapy
[ ] Weight Management Program: Kevin Lai, MD & Associates
[ ] Mind fullness-Based Eating Awareness Training (MB-EAT) Group Therapy: Neil Levitsky, MD
[ ] Small Office Procedures

Psychotherapist, Rehab Clinic, Dietitian, or Foot Clinic:
No referral necessary (but much appreciated) to access any of the multi-disciplinary health providers.

Referred by:

____

Physician Referral Required Services: #
Referring Physician Name: ______________________ *
MOHLTC Billing Number: ______________________ *
Referring Physician Phone: ______________________ *
Referring Physician Fax: ______________________ *

Physician Signature: ______________________ *
Date of Referral: ______________________ *

***** Please send a copy of recent relevant blood work, investigations, imaging, and consults *****

[v.20.08.09]