Mindfulness-Based Eating Awareness Training
649 Sheppard Ave West
Toronto, ON, M3H 2S4
TEL: (416) 508-5691 | FAX: (647) 478-7604

www.getwellforlife.ca

Dear doctor

Your patient has expressed interest in ***MB-EAT Group Therapy!***

PATIENT INFO:

(* Required fields)

Name: ________________________________ *

Date of Birth: ______________________ (dd-mm-yyyy)

Gender: __________

OHIP #: ___________________ * Version: _______ *

Address: ___________________________

____

City: _______________ Postal Code: ___________

Phone: _____________________ *

Cell: _____________________

Email: _____________________

(personal, non-work)

Medical Reason for Referral: * (Examples: obesity, HTN, diabetes, cholesterol, depression/anxiety etc.)

Past Medical and Psychiatric Health: **Height:** _______ **Weight:** _______

Current Medications:

Referral request to ***Dr. Neil Levitsky*** *(Psychiatrist) for assessment regarding enrolling in Group Therapy.*	**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.19.05.20]