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
Rachel Zeng, RP, RSW
Child & Youth:
[ ] Behavioural Analyst
Amelia Bowler, BCBA
Rehab Clinic:
[ ] Chiropractic / Acupuncture
Dr. Gordon Lee, DC
[ ] Physiotherapy
Leo Chau, PT
Nutrition & Weight Loss:
[ ] Dietitian
Rita Lau, RD
Foot Clinic:
[ ] Chiropody / Foot Clinic
Shannon Youn, DCh
[ ] Compression Stockings
[ ] Custom Orthotic Insoles

Physician Referral Required: #
[ ] Mental Health
Laura Lee Copeland, MD
Kevin Lai, MD
[ ] Weight Loss Program
Kevin Lai, MD, Rita Lau, RD
[ ] Small procedures (skin, nail)
Joyce Lui, MD
[ ] Palliative Care
Joyce Lui, MD

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.18.05.23]