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

getwell clinic.ca

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
Rosanna Lee, RD
Foot Clinic:
[ ] Chiropody / Foot Clinic
Shannon Youn, DCh
[ ] Compression Stockings
[ ] Custom Orthotic Insoles

Physician Referral Required: #
[ ] Mental Health Program
[ ] Small Office Procedures
[ ] Weight Management Program
Kevin Lai, MD & Associates

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 *****