REFERRAL FORM
FAX to 1-855-844-0979

☐ Assessment and authorization OR ☐ Education and support only

Date: _____ Referred by: _____

Clinic name: _____ Clinic phone #: _____

Clinic email: _____ Clinic fax #: _____

Patient name: _____ Phone #: _____

Email: _____ Health card #: _____

Substitute decision maker/alternate contact (if applicable):

Name: _____ Phone #: _____

Diagnosis:

- ☐ Chronic pain (i.e. Osteoarthritis, Headache, CPSA, Fibromyalgia, Herniated disc, Post- herpetic neuralgia, etc.)
- ☐ Inflammatory diseases (i.e. Colitis, IBS, RA, AS, etc.)
- ☐ Cancer
- ☐ Sleep disorders
- ☐ Neurological disorders (i.e. MS, ALS, Tourette syndrome, Parkinson's disease, Alzheimer's disease, etc.)
- ☐ Mental health (i.e. anxiety disorders, PTSD, OCD, etc.)
- ☐ Women's health (i.e. Dysmenorrhea, PMS, endometriosis, chronic pelvic pain, etc.)
- ☐ Geriatric
- ☐ Other (please specify): _____

Contraindications/Cautions:

- ☐ Under 18 years old
- ☐ Breastfeeding and/or Pregnant
- ☐ Schizophrenia/Bipolar/Psychosis (must provide letter from Psychiatrist)
- ☐ Unstable cardiovascular disease

Comments (anything else you feel we should be aware of in regard to this patient/referral?):