



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?):  
\_\_\_\_\_  
\_\_\_\_\_

CONFIDENTIALITY NOTICE: The information contained in this facsimile message is legally privileged and intended for the named recipient only. If you have received this information in error, you are hereby notified that any review, dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy this communication.