



Headquarters:  
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 Toll Free Fax #: 866 821 0777

Fax complete package toll free to:  
**1 866 821 0777**

Patient needs help with video setup?  
 Y  N   LTC

Independent Living  Assisted Living

## Consult Referral

### Patient Information:

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_  
MM/DD/YYYY

Patient's Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Residence: \_\_\_\_\_ Unit #: \_\_\_\_\_ E-mail: \_\_\_\_\_

Health Card #: \_\_\_\_\_ Health Card Expiry: \_\_\_\_\_  
MM/DD/YYYY

Do you have an open Motor Vehicle Accident Claim? Y  N  | Have you ever used Cannabis? Y  N

Are you a veteran? Y  N  If yes, K# \_\_\_\_\_ Appointment time preference:  Daytime  Evening  Weekends

Reason for Assessment:  Pain  Anxiety  Sleep  BPSD  Depression  Cancer  Fibromyalgia  PTSD  Other

Current medical conditions (please provide a copy of medical records, including consults + prior treatments)

History of Bipolar  
 History of Schizophrenia  
 History of Psychosis

## REFERRING HEALTHCARE PROFESSIONAL

\_\_\_\_\_  
 Healthcare Professional name (print) Healthcare Professional signature MM/DD/YYYY

Healthcare Professional phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_ E-mail: \_\_\_\_\_

Designation: \_\_\_\_\_ Billing #: \_\_\_\_\_