649 Sheppard Ave West
Toronto, ON, M3H 2S4
TEL: (416) 508-5691 | FAX: (416) 398-2436

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 elds)

Reason for Referral:

Past Medical and Psychiatric Health:

Current Medications:

Weight Management Program
[ ] Dr. Kevin Lai
Suzanna Lai, RP

Mental Health:
[ ] Psychotherapy

Child & Youth:
[ ] Behavioural Analyst

Rehab Clinic:
[ ] Chiropractic / Acupuncture
[ ] Physiotherapy
[ ] Massage Therapy

Nutrition & Weight Loss:
[ ] Nutritionist
[ ] Registered Dietitian

Foot Clinic:
[ ] Chiropody / Foot Clinic
[ ] Compression Stockings
[ ] Custom Orthotic Insoles

Cosmetic Procedures:
[ ] Botox & Fillers
[ ] Lumps and Bumps Removal

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 *****
Thank you very much for your referral