

Patient Referral Form

Physician

Referring Physician: _____

Elective Urgent

Office Address: _____

(City) _____ (Prov.) _____ (Postal Code) _____

Telephone #: _____ Fax #: _____

Email address: _____

Patient

Name: _____

First

Last

D.O.B.: (DD/MM/YYYY): ____ / ____ / ____

Sex: M F

OHIP #: _____

Contact #: _____

Address: _____

Please outline the attention/focus concerns:

Patient Care To Date:

Vision Screening	Yes / No	If yes, Date: _____
Audiogram	Yes / No	If yes, Date: _____
Central Auditory Processing	Yes / No	If yes, Date: _____
Speech and Language Assessment	Yes / No	If yes, Date: _____
Psychological Assessment	Yes / No	If yes, Date: _____
Occupational Therapy	Yes / No	If yes, Date: _____
Conners Evaluation	Yes / No	If yes, Date: _____
Physical Examination	Yes / No	If yes, Date: _____
ECG	Yes / No	If yes, Date: _____
EEG	Yes / No	If yes, Date: _____
Other Assessments:	_____	

Current Medications

Medication Name: _____ Dosage: _____

Medication Name: _____ Dosage: _____

Medication Name: _____ Dosage: _____

Physician Signature: _____ Date: _____

*Dr. Gray is an identified psychotherapist with the Ministry of Health; therefore, services provided to enrolled patients from FHN, FHO or GHC will not contribute to outside use and will not impact Access Bonuses.

**The Springboard Clinic evaluation includes non-insured services outlined at the initial visit, which costs \$200.00.