www.wholemedhealth.com

MEDICAL REFERRAL

Fax to: 416-245-7633

First Name: _____ **Last Name:** _____

Tel: # _____ **Email:** _____

Address: _____

City: _____ **Postal Code:** _____

Date of Birth: _____ **Health Card:** _____

Please include two letters if you have the green card.

Reason for Referral (Please include medical summary reports)

Current and Past Treatments:

Please provide any other Relevant Health Information:

*A consultation appointment will be scheduled once ALL the requested information has been received and reviewed.

Referring Physician:

FULL NAME: _____ **REFERRAL DATE:** _____

ADDRESS: _____

TELEPHONE: _____ **Fax:** _____

SIGNATURE: _____

FAX to: 416-245-7633 Your patient will be assessed by a licensed and practicing physician.

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Fax: 416 245-7633
info@wholemedhealth.com