Physician Referral Form

PhytoMedical

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Patient Information

In need of telemedicine appointment? □ **Yes**

Name: _____ **Date of Birth:** _____
(Frist) (Last) (MM/DD/YYYY)

Healthcard: _____ **Phone number:** _____
(including version)

Street address: _____ **Province:** _____ **Postal Code:** _____

Email: _____

Reason for Referral

- □ Chronic pain
- □ Arthritis
- □ Fibromyalgia
- □ Cancer
- □ Multiple sclerosis
- □ Parkinson's disease
- □ Seizure disorder
- □ Gastrointestinal
- □ AIDS/HIV related
- □ Post traumatic stress disorder
- □ Sleep disorder
- □ Anxiety/depression

Other: _____

Current Medications: (name and doseage)

_____
_____
_____
_____

Medications used in past for current condition:

_____
_____
_____
_____

Physician Information

Name: _____

Lisence number: _____

Address: _____

_____

Phone number: _____

Fax: _____

Physician stamp here

PLEASE SEND MEDICAL DOCUMENTATION RELATING TO REFERRING ILLNESS
(laboratory tests, imaging, visit notes)