FIRST STEP
MEN'S THERAPY

**Insert Patient Identification Label Here**

# Physician Referral Form

## Please fax referrals to: (613) 236-0743 (PHIPA complaint)

**Patient Information:**

Name _____

Phone _____ Email _____

Address _____

DOB (M/D/Y) _____ Gender _____

Preferred Method of contact: ☐ Phone ☐ Email

**Referring Physician Information:**

Name _____ CPSO # _____

Phone _____ Fax _____

Clinic Address _____

Please select from the following options. The patient is presenting issue(s) of:

☐ Anxiety ☐ Depression ☐ Chronic Pain ☐ Insomnia ☐ Addiction ☐ Grief

☐ Stress ☐ Burnout ☐ Sexual Issues (ED) ☐ Other

Additional information:

| |
|---|
| |

Progress report, with patients consent after:

☐ Three Months ☐ Six Months ☐ Upon Request

Physician Signature: _____ Date: _____

359 Kent Street, Suite 510, Ottawa, ON K2P 0R6 Ph: (613) 917-0765 Fax: (613) 236-0743

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