

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:

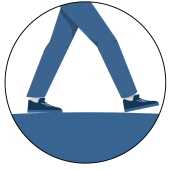
- Anxiety  Depression  Chronic Pain  Insomnia  Addiction  Grief  
 Stress  Burnout  Sexual Issues (ED)  Other

Additional information:

Progress report, with patients consent after:

- Three Months  Six Months  Upon Request

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**FIRST STEP  
MEN'S THERAPY**

**Insert Patient Identification Label Here**