Springboard Clinic Referral Form

Patient Information

First Name: _____ Last Name: _____

Date of Birth: _____ Sex: M / F

Health Card No.: _____ Phone No.: _____

Reason for Consultation:

_____

_____

_____

_____

Significant Concurrent Problems:

_____

_____

Current Medications:

_____

_____

**Please feel free to attach any other pertinent clinical information

Referring Physician

Name: _____ OHIP Billing No.: _____

Phone No.: _____ Fax No.: _____

Physician Signature Date

Please fax the completed form to (416) 901-3079 or email it to info@springboardclinic.com