Springboard Clinic
1055 Yonge St., Suite 301
Toronto ON M4W 2L2
Tel: 416.901.3077

Springboard Clinic Referral Form

Patient Information:

Surname: _____ Given Name(s): _____

D.O.B.: (dd/mm/yyyy): _____ Sex: M / F

Health Card No: _____ Phone No.: _____

Email: _____ Address: _____

_____

Reason for Consultation:

_____

_____

_____

Significant Concurrent Problems:

_____

_____

_____

Past Psychiatric/Medical History:

_____

_____

_____

Current Medications:

_____

_____

_____

Past Psychiatric Medications:

_____

_____

_____

Other Relevant History:

_____

_____

Referring Physician:

Do you provide ongoing care for this client? Y / N How frequently do you see this client? _____

Name: _____ OHIP Billing No.: _____

Phone No.: _____ Fax No.: _____

_____ _____

Date Physician Signature

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