Greenleaf
MEDICAL CLINIC

#218-9525 201 Street
Langley, BC V1M 4A5
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PATIENT REFERRAL FORM

PHYSICIAN INFORMATION		
Referring Physician:	Phone #:	Billing #:
Family Physician:	Phone #:	

PATIENT INFORMATION				
Last Name:	First:	Middle:	☐Mr ☐Mrs ☐Ms.	Sex: ☐F ☐M
Date of Birth (dd/mm/year):		Personal Health Number:		
Address:	City:	Province:	Postal Code:	
Home Phone #:	Work Phone #:	Cell Phone #:		

PATIENT MEDICAL HISTORY

☐ADD/ADHD	☐Complex Regional Pain Syndrome	☐Jaw Pain
☐Alzheimer's / Dementia	☐Depression	☐Menopause / Libido
☐Anxiety	☐Eating Disorders	☐Migraines
☐Autism / Developmental Delay	☐Epilepsy / Seizures	☐Multiple Sclerosis
☐Appetite/Nausea	☐Tremors / Parkinson's	☐Muscle Spasms
☐Arthritis. Type: _____	☐Fibromyalgia	☐Pelvic Pain / PMS
☐Back/Neck Problems	☐GI (Colitis, Crohn's, IBS, etc)	☐Post Operative Surgery Pain
☐Bladder Pain	☐Glaucoma	☐PTSD
☐Brain / Spinal Cord Injury/Disease	☐Hepatitis	☐Repetitive Strain Injury
☐Cancer / Cancer Related Symptoms	☐HIV/AIDS	☐Sleep Disorders
☐Chronic Pain / Nerve Pain	☐Other_____	

Please select medication that has been tried: ____

☐Gabapentin/Lyrica	☐Muscle Relaxants	☐Opioids	☐NSAID	☐SSRI
☐IV Lidocaine	☐IV Ketamine	☐Nabilone	☐Tramadol	☐Amitriptyline/Nortriptyline

Does the patient have any UNCONTROLLED mania, schizophrenia, depression, using sedatives/hypnotics/other psychoactive drugs?	☐Yes ☐No

DO SEND: **Any injury or disease relevant imaging such as Xray, CT, MRI, etc. As well as relevant consults (psych, neuro, rheum and surgical.)**

DO NOT SEND: **Bloodwork results or medication list.**

OTHER MEDICAL HISTORY

PHYSICIAN SIGNATURE: **DATE:**