Greenleaf
MEDICAL CLINIC

PATIENT REFERRAL FORM

☐ URGENT ☐ SEMI-URGENT

#218-9525 201 Street
Langley, BC V1M 4A5
t: (604) 371-4769
f: (604) 371-2044
www.greenleafmc.ca

PHYSICIAN INFORMATION

Referring Physician:	Phone:	Fax:
Billing #:		
Family Physician:	Phone:	Fax:

PATIENT INFORMATION

Last Name:	First :	Middle:	Sex: ☐ M ☐ F
Date of Birth: (dd/mm/yyyy)	Personal Health Number:		
Address:	City:	Province:	Postal Code:
Home Phone:	Cell Phone:	Email:	

PATIENT MEDICAL HISTORY

MENTAL HEALTH CONDITIONS

- ☐ ADD/ADHD
- ☐ Anxiety
- ☐ Autism/Developmental Delay
- ☐ Bi-Polar
- ☐ Depression
- ☐ Eating Disorder
- ☐ PTSD
- ☐ Sleep Disorder
- ☐ Schizophrenia

GASTROINTESTINAL CONDITIONS

- ☐ Appetite
- ☐ Colitis
- ☐ Crohn's Disease
- ☐ Hepatitis
- ☐ Irritable Bowel Syndrome
- ☐ Nausea

NEUROLOGICAL/PAIN CONDITIOINS

- ☐ Alzheimer's Disease
- ☐ Arthritis-Osteoarthritis
- ☐ Arthritis-Rheumatoid Arthritis
- ☐ Back & Neck Pain
- ☐ Bladder Pain
- ☐ Brain/Head Injury/Concussion
- ☐ Central Sensitivity Syndrome
- ☐ Chronic Pain/Neuropathic Pain
- ☐ Complex Regional Pain Syndrome
- ☐ Degenerative Disc Disease
- ☐ Epilepsy/Seizures
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Jaw Pain
- ☐ Migraines
- ☐ Muscle Spasms
- ☐ Parkinson's Disease
- ☐ Pelvic Pain/Endometriosis
- ☐ Post Surgical Pain
- ☐ PMS/Menstrual Cramps
- ☐ Repetitive Strain Injury
- ☐ Spinal Cord Injury/Disease
- ☐ Trauma

CANCER CONDITIONS

- ☐ Appetite
- ☐ Cancer
- ☐ Nausea
- ☐ Pain

MISC./OTHER CONDITIONS

- ☐ Chronic Fatigue Syndrome
- ☐ Fatigue
- ☐ Other
- ☐ HIV/AIDS
- ☐ Libido
- ☐ Menopause
- ☐ POTS

Please select medication that has been tried:

- ☐ Gabapentin/Lyrica
- ☐ IV Lidocaine
- ☐ Muscle Relaxants
- ☐ IV Ketamine
- ☐ Opioids
- ☐ Nabalone
- ☐ NSAIDS
- ☐ Tramadol
- ☐ SSRI
- ☐ Amitriptyline/Nortriptyline

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

DO SEND: List of medications. 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.

Other Medical History:

Email referral to: fax@greenleafmedicalclinic.ca OR Fax referral to 1-604-371-2044

Physician Signature: **Date:**