Greenleaf
MEDICAL CLINIC

# PATIENT REFERRAL FORM

☐ URGENT ☐ SEMI-URGENT

Suite 401 505-8840 210 St
Langley, BC V1M 2Y2
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 ☐ Muscle Relaxants ☐ Opioids ☐ NSAIDS ☐ SSRI
☐ IV Lidocaine ☐ IV Ketamine ☐ Nabalone ☐ Tramadol ☐ 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:**