CAN-BIND Canadian Biomarker Integration Network in Depression

PATIENT REFERRAL FORM

DATE OF REFERRAL: _____

Patient's name: _____ DOB: _____ Age: _____
(dd/mmm/yyyy)

Address: _____

_____ Postal Code: _____

Tel: H(_____) _____ W(_____) _____

Health Card Number: _____Version Code: _____ MRN: _____

REFERRING PHYSICIAN: (*Patient must be referred by a physician*) ☐Family Physician ☐Psychiatrist

Name: _____ Billing Number: _____

Address: _____

_____ Postal Code: _____

Tel: (_____) _____ Fax (_____) _____

Email: _____

REFERRAL DETAILS

WORKING DIAGNOSIS: _____

PRESENTLY UNTREATED: ☐YES ☐NO

CURRENT SYMPTOMS:

CURRENT MEDICATION(S): ☐NONE

PAST MEDICATION(S): ☐NONE

MEDICAL ILLNESSES: ☐NONE

TORONTO ● **Fax# 416-603-5368 (Attn: Dr. Sidney Kennedy)**
HAMILTON ● **Fax# 905-381-5618 (Attn: Dr. Benicio Frey)**
KINGSTON ● **Fax# 613-540-6126 (Attn: Dr. Roumen Milev)**
CALGARY ● **Fax# 403-210-9346 (Attn: Dr. Glenda MacQueen)**
VANCOUVER ● **Fax# 604-822-7922 (Attn: Dr. Raymond Lam)**