THRIVE MEDICAL

1575 Jane St #7, North York, ON M9M 2R3
Phone: 647-945-1100 | Fax: 647-749-0131
thrivemedical.ca

Reset

REFERRAL FORM

PATIENT INFORMATION

Name: _____ HCN & VC: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female ☐ _____

Phone Number: _____ Can messages be left: ☐ Yes ☐ No

REASON FOR REFERRAL

Please check all that apply.

☐ Opioid Use Disorder
☐ Alcohol Use Disorder
☐ Stimulant Use Disorder
☐ Cannabis Use Disorder
☐ Smoking Cessation
☐ Other: _____

MEDICAL HISTORY

Please enter psychiatric, medical history, medications, blood work or attach separately.

REFERRING PROVIDER / ORGANIZATION INFORMATION

Name: _____ Billing Number (if applicable): _____

Phone Number: _____ Fax Number: _____

Signature: _____ Date: _____

Services are fully covered by OHIP. Please remind patients to bring a valid health card.

Thank you for the referral and the opportunity to support your patients health.