All Brains Clinic
WHERE COMMUNITY MEETS CARE

Referral Form

After completing the form, please fax it to (844) 927-0222.

Patient's Contact Information

Name: _____

Date of Birth: (YYYY/MM/DD) _____ / _____ / _____

PHN: _____

Phone Number: _____

Email Address: _____

Address Line: _____

City: _____ **Province:** _____

Postal Code: _____

Guardian consent for email communication: ☐ **Yes** ☐ **No**

Are there current court/medical legal and/or custody matters? ☐ **Yes** ☐ **No**

Previous diagnosis: ☐ **Yes** ☐ **No**

If "Yes", identify diagnosis:

_____

_____

_____

_____

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Medication and Dosage (past and current)

Medication	Dosage	Date

Psychiatric/Medical History

Physician's Information

Name:

Billing Number:

Phone Number:

Fax Number:

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Reason for Referral (indicate all that apply)

- [ ] Comprehensive Autism Assessment
- [ ] In-depth Psychoeducational Assessment
- [ ] Multi-disciplinary ADHD/ADD Assessment
- [ ] Early Language and Social Development Assessment
- [ ] General Diagnostic Assessment

Date:
(YYYY/MM/DD) _____ / _____ / _____

Signature

Please fax any other clinical or supporting document to (844) 927-0222.

Address: **5933 Birney Ave, Vancouver, BC V6S 0G7**
Tel: **(604) 998-2244**
Fax: (844) 927-0222
Email: **info@allbrainsclinic.com**