

Primary Care Referral Form

Dr. R. Agnihotri - Lifestyle Medicine Paediatric Mental Health Consultation

FAX: 289-438-0123

Patient's Personal Information

Name:		Pref. Name:		Health Card Number & VC:	
Address :		City :		Postal Code	
Telephone :		Cell :		Other :	
DOB :		Age :		Gender :	
Parent's Name :			Parent's Name :		
Resides with : (Choose)			Custody Type: N/A ☐ Joint ☐ Sole ☐		
Family Physician :			Telephone : - -		
			Telephone : - -		

Referral Information

Referred by :	Date :	Physician's Billing # :
---------------	--------	-------------------------

Reason for Referral (Required):

Medication

List of Current Medications-Please print clearly

Name of Medication	Dosage	Frequency
Allergies		

Consent and Agreement

I/, WE THE UNDERSIGNED AGREE TO THE EXCHANGE OF PERSONAL HEALTH INFORMATION BETWEEN AND PATHSTONE MENTAL HEALTH. I FURTHER AGREE TO THE PERSONAL HEALTH INFORMATION EXCHANGE BETWEEN PATHSTONE MENTAL HEALTH AND NIAGARA HEALTH BE COLLECTED, USED, OR DISCLOSED FOR THE PURPOSE OF REFERRAL, TREATMENT PLANNING, COORDINATION AND FOLLOW UP SERVICES/SUPPORTS. I ALSO AGREE TO A SOCIAL WORKER CALLING ME FOR THE PURPOSE OF COMPLETING AN INTAKE.

SIGNATURE

DATE