FIRST STEP
MEN'S THERAPY

Physician Referral Form

Please fax referrals to: (613) 236-0743 or **(289) 721-2018 (PHIPA complaint)**

Patient Information:

Name _____

Phone _____ Email _____

Address _____

DOB (M/D/Y) _____ Gender _____

Preferred Method of contact: ☐ Phone ☐ Email

Referring Physician Information:

Name _____ CPSO # _____

Phone _____ Fax _____

Clinic Address _____

Please select from the following options. The patient is presenting issue(s) of:

☐ Anxiety ☐ Depression ☐ Chronic Pain ☐ Insomnia ☐ Addiction ☐ Grief

☐ Stress ☐ Burnout ☐ Sexual Issues (ED) ☐ Other

Additional information:

Progress report, with patients consent after:

☐ Three Months ☐ Six Months ☐ Upon Request

Physician Signature: _____ Date: _____

414-396 Cooper Street, Ottawa, ON Ph: (343) 453-5084 Fax: (613) 236-0743