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 and any accompanying comorbid psychiatric disorder.
- [ ] In-depth Psychoeducational Assessment and any accompanying comorbid psychiatric disorder.
- [ ] Multi-disciplinary ADHD/ADD Assessment and any accompanying comorbid psychiatric disorder.
- [ ] Early Language and Social Development Assessment and any accompanying comorbid psychiatric disorder.
- [ ] General Diagnostic Assessment and any accompanying comorbid psychiatric disorder.

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

Signature:

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

Address: **6205 West Blvd**
Vancouver, BC V6M 3X4

Tel: **(604) 998-2244**

Fax: (844) 927-0222

Email:
info@allbrainsclinic.com