ORIDON MEDICAL
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F: 416 444 1663
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PLEASE EMAIL OR FAX TO:
E: admin@oridonmedical.ca
F: 416 444 1663
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Please attach all relevant documents pertaining to diagnosis

Patient Referral Form

☐ **REFERRAL IS URGENT** (will contact within 24 hours)

Reason(s) for Referral

Mental Health

- ☐ Depression
- ☐ Anxiety
- ☐ PTSD
- ☐ Eating Disorder
- ☐ ADHD
- ☐ Other _____

Neurologic

- ☐ Multiple Sclerosis
- ☐ Post-CNS Insult
- ☐ Seizure Disorder/Epilepsy
- ☐ Parkinson's Disease
- ☐ Dementia Related Agitation
- ☐ ALS
- ☐ Tourette's Syndrome
- ☐ Other _____

Gastrointestinal

- ☐ Nausea/Vomiting Relating to Chemotherapy
- ☐ Functional Abdominal Pain
- ☐ Irritable Bowel Syndrome
- ☐ Inflammatory Bowel Disease
- ☐ Other _____

Pain Syndrome

- ☐ Osteoarthritis
- ☐ Inflammatory Polyarthropathy
- ☐ Fibromyalgia
- ☐ Back Pain, Non-inflammatory
- ☐ Muscle Pain, Non-inflammatory
- ☐ Cancer Pain
- ☐ Palliative Pain
- ☐ Migraines/Tension Headaches
- ☐ Neuropathic Pain (Diabetic/Post herpetic/Sciatic)
- ☐ Other _____

Other

- ☐ Opioid Overuse/Withdrawal
- ☐ Alcohol Misuse
- ☐ Insomnia
- ☐ HIV/AIDS
- ☐ General Wellness
- ☐ Other _____

Important (check all that apply):

- ☐ Currently taking Anticoagulants
- ☐ Pregnant, Breastfeeding or Family Planning
- ☐ Personal/Family History of Psychosis
- ☐ Uncontrolled Psychiatric Illness

Current Medications (or attach list):

Previously Attempted Therapies:

Patient Information

Full Name: _____ DOB (YYYY/MM/DD): _____ Sex: ☐ M ☐ F ☐ Other

Address: _____ Email: _____

Tel: _____ Ver. Code: _____ Health Card #: _____

Physician Information

Full Name: _____ Billing #: _____ Signature: _____

Address: _____ Tel: _____ Fax: _____

Physicians at Oridon Medical do not bill family practice codes. No fees are charged to the patients. We will contact the patient to arrange an appointment. Patients are usually seen within 2 weeks.