|  |  |
| --- | --- |
| ***Physician Referral Form*** | **Environmental Health Clinic** Tel: (416) 351-3764Fax: (416) 323-6130 |
|  |
| **Patient Information *(Must be fully completed)*** |
| Name: |  |  |
| DOB: |  |  |
| Address: |  |  |
| HC# |  |  |
| Tel:  |  |  |
|  |  |  |  |  |
|  |  |
| **1.**  | **Referring Condition:*** Chronic Fatigue Syndrome
* Electromagnetic Hypersensitivity
* Fibromyalgia
* Multiple Chemical Sensitivity
 |
|  |  |
|  |  |
|  |  |
|  |  |
| **2.**  | **Other Problems** *(Health Hx).* |
|  |  |
|  |  |
|  |  |
|  |  |  |  |
| **3.** | **Prior Investigations** | **4.** | **Current Medications, Supplements or Treatments** |
|  | (please enclose relevant reports) |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **5.** | **Prior Consultations**  | **6.** | **Purpose of referral to Environmental**  |
|  | (please indicate below and enclose relevant consultant’s reports) |  | **Health Clinic:** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |
| **Referring Physician Information** *(Must be fully completed)* |  |
| Name: |  |  |  |
| Address: |  |  |  |
|  |  |  |  |
| Tel: |  |  |  Date: |  |  |
| Fax: |  |  |  |
| Email: |  |  |  |  | MD |
| Physician Billing Number: |  |  |  |  |  |
|  |  |