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