WCHI
WOMEN'S COLLEGE HOSPITAL
Healthcare | REVOLUTIONIZED
76 Grenville Street
Toronto, Ontario
M5S 1B2
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ENVIRONMENTAL HEALTH CLINIC (EHC) REFERRAL FORM

REFERRAL DATE: ____/____/_____
DD / MM / YYYY

PATIENT INFORMATION
(Affix Patient Label/Identification Here)

MRN:_____ HCN:_____
Name:_____
Sex:_____ Date of Birth:____/____/_____
DD / MM / YYYY
Address:_____
Telephone:_____ Alternate #:_____

SPECIFIC PHYSICIAN: ☐ No (First available) ☐ Yes: Dr. _____

ADDITIONAL PATIENT INFORMATION

Preferred name: Gender (*if not same as above*):

Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ _____

Other insurance coverage (IFH, UHIP, etc.):

Language spoken: Interpreter required: ☐ Yes ☐ No

REFERRING PROVIDER INFORMATION

Name:
Address:
Telephone:
Fax:

Billing #: _____
Signature: _____

❑ Referring Provider is not the Primary Health Care Provider
Primary Health Care Provider Name:_____ Phone:_____ Fax:_____

REASON FOR REFERRAL TO EHC

Clinic <u>inclusion</u> criteria:
- Chronic Fatigue Syndrome (CFS) / Myalgic Encephalomyelitis (ME)
- Chemical sensitivity
- Electromagnetic Field Hypersensitivity
- Mold exposure
- Known exposure (non-occupational)
- Toxic metal overload
- Post treatment Lyme Disease Syndrome

Clinic <u>exclusion</u> criteria:
- Rheumatological conditions
- Thalassemia/blood disorder
- Uncontrolled mental health disorders:
  e.g. schizophrenia of any subtype, delusional disorder, major anxiety and depression, Morgellon's Syndrome, Parasitosis

Reason for Consult:

Please attach all relevant results/reports:

☐ Consultation reports

ADDITIONAL CLINICAL INFORMATION

Past and current medical history:

Allergies and reaction:

Current medications (include list):

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